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LEADING ARTICLES

• COMPLETE TABLE OF CONTENTS ON ADVERTISING PAGE FOUR •

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THOMAS LINACRE, M.D.

CLINICAL MEDICINE AND SURGERY

GEORGE B. LAKE, M.D.
• *Editor* •

VOL. 42 MARCH, 1935 NO. 3

EDITORIAL

Dr. Thomas Linacre

"Restorer of Learning"

KING HENRY VIII, of England, and his lurid, picturesque and polygamous matrimonial performances have been so widely publicized, of late, that a sketch of his personal physician, who found a whole clinic in the festering body of his royal patient, should be of interest.

Thomas Linacre was born in England in 1460. As the science of demography was, as yet, unborn and vital statistics non-existent, the month and day of his birth and death are not recorded.

He must have come of a substantial family, for when he decided to study medicine he went to Italy, which was then the great center of medical education, and received his Doctorate in Medicine from the University of Padua. After returning home he took a similar degree from Oxford University. These events must have occurred a number of years before 1509, for he had time to acquire sufficient reputation in his profession to be appointed physician to King Henry VII, the founder of the Tudor dynasty, who died in the year last mentioned.

When the robustious Henry VIII ascended the throne, upon the death of his father, Dr. Linacre was continued in his royal appointment, which certainly was no sinecure from that time on until the Doctor's death, in 1524.

But his medical career was only a part of Linacre's claim to remembrance. He was a priest and a great scholar, as well as a physician—so much so that, because of his services to humanism, he has been called the "Restorer of Learning in England." He is remembered chiefly for his works on grammar (it has been suggested that he was the "Grammarian" immortalized by Robert Browning), for his founding of lectures on medicine at Oxford and Cambridge Universities, and for his accurate and elegant translations of the works of the great Greek physician, Galen, into Latin. These faithful versions of the treatises on hygiene, therapeutics, temperaments, natural faculties, the pulse, and symptomatology, had a wide circulation on the Continent, as well as in England, and were highly esteemed by several generations of physicians.

When we recollect how meager was the knowledge of the basic sciences of medicine, and how limited the professional armamentarium of the physician of 400 years or so ago, we must offer deep respect to the personal power and accomplishments of a man who could serve two kings, in those turbulent and semi-barbarous days, and still find time and inclination to make a name for himself as a scholar and humanist.

"Poor Prunes"

THE slangy epithet which heads this editorial was applied, with force and cogency, to the physicians of the United States, by an editorial writer in *The Private Physician* for October, 1934.

In the salary list of the Moving Picture Industries, the largest single item is the attorney's salary—$100,000.00 a year—while near the bottom appears, "Medical director's salary, $7,000.00."

Now the hundred-thousand dollar attorney was as much a victim of the "Depression" as the seven-thousand-dollar medical director. It begins to look as if the medical profession had sold its birthright for a mess of pottage—and a small mess at that.

It is easy enough to blame our troubles on abuses of charity, free and pay clinics, "relief" rackets and other politically controlled agencies, the lack or inefficiency of leaders, or any other thing that strikes one's fancy, but these things seem not to have affected the lawyers very noticeably. It begins to look as if the private physicians of this country are suffering from their own ignorance, indifference, lethargy and lack of backbone.

Medicine is a noble art and science, as it always has been, but while its votaries content themselves with declaiming about it and about a misunderstood and misconstrued Code of Ethics, the advance guard of State Medicine is now closing in on our flanks, and if we wait until the main body comes up before we take any action, there won't be much left of us when the smoke of battle has cleared away.

All these disasters, present and to come, can be prevented and corrected if the physicians will organize—not, as now, merely in societies for professional study and advancement, but in cohesive and well coordinated groups for economic and political action. If not, the outcome will be the result of lack of personal guts in our noble profession.

Nobody but physicians can practice medicine legally. If we refuse to work for tax-supported institutions without receiving adequate pay, and for dispensaries which pay their clerks, janitors, social service workers and others, unless they pay their physicians as promptly and on a scale proportioned to their professional training, these will have no recourse but to meet our demands.

But to make such a program effective we must *work fast and in harmony;* agree on principles and *stick to them;* draw up codes and fee schedules and *enforce them.* It is perfectly simple if the physicians can be shaken out of their Rip Van Winkle trance.

Make the acquaintance of your United States senators and congressmen; your state assemblymen; your county and city bosses, either personally or by correspondence, and *talk turkey to them,* the same as other groups and interests do. This can be done with good grace, for the motive will be, at worst, less than fifty percent selfish. The people *need* the private physician. Prove this to them and to the politicians, and the fight will be won.

If, in the near future, we find ourselves working under the dictation of self-seeking lay politicians, for wages which a ditch-digger or window-washer would scorn (and that is not such a wild flight of imagination), we should not be resentful at being called "poor prunes," for the remedy is in our own hands *now.* Tomorrow it may be too late.

If we could first know where we are and whither we are tending, we could better tell what to do and how to do it.—A. LINCOLN.

The Nation's Health

THE report of the Surgeon General of the U. S. Public Health Service, covering the year 1933 and the first half of 1934, contains a number of bits of information which will be of general interest.

During the period covered by this report, there was no evidence that the disastrous economic conditions during the past lustrum have had any untoward effect upon the health of the people of this country, except in that group which was in comfortable fiduciary circumstances in 1929, but has since been forced to live on a much lower level. The reasons assigned for this maintenance of the Nation's health are the vast expenditures of the relief agencies and the absence of widespread epidemics during the period.

During the calendar year 1933, the death rate was the lowest ever recorded in the United States (10.5 per 1,000 of population); the deaths from tuberculosis continued to decrease; and the mortality from typhoid fever and diphtheria was the lowest ever recorded by the Public Health Service.

In spite of the fact that a number of European countries have advanced so far in preventive measures that they did not have a single case of smallpox in 1933, this country, due to the activities of the fanatical anti-vaccinationists, recorded 7,000 cases, with 40 deaths, during that period.

The birth rate declined one per thousand, as compared with 1932; but the coincident fall in the infant death rate kept the balance about even.

By means of animal experimentation, a new method has been discovered for the treatment of bichloride of mercury poisoning in human beings. In actual cases, death from otherwise fatal doses of corrosive sublimate has been prevented by the intravenous and per-oral administration of formaldehyde sulphoxylate, within a reasonable time after the poison has been swallowed.

Travelers will be glad to learn that the water for drinking purposes, not only on trains and ships, but also on busses and airplanes engaged in interstate passenger transportation, is now inspected and certified by the Public Health Service.

One of the most interesting features in this report deals with international air transportation of passengers, which has now become so extensive that, on April 6, 1934, the International Sanitary Convention for Aerial Navigation was signed by 23 countries, including the United States, for the regulation of airplane traffic in the interest of international health. During the fiscal year covered by this report, 3,668 airplanes, carrying 26,951 passengers, arrived at 57 airports in the United States from foreign ports, requiring quarantine inspection.

Under ordinary conditions, most people (including physicians) have a tendency to forget the Public Health Service and its invaluable work; but if it were not for the multiplex activities of this remarkable institution, continued daily throughout the year, our national health would be far less satisfactory than it is today.

The longer a malady remains uncured, the greater the temptation to consult quacks.—ROBERT QUILLEN.

The Old Doctor

RUMORS have gone about, now and then, that, in various localities, elderly physicians, who had, perhaps, been better doctors than business men, have been, and possibly still are, on "relief" rolls.

Wherever and in so far as these reports are true, it is a pitiful thing that these citizens, who have given their lives (perchance to their own detriment) in the service of their fellows, should come to the distress and humiliation of being the recipients of public or private charity. It may well be that, if those who owed them money had paid their debts, such a tragedy need not have occurred.

What can those physicians, who are in the midst of their earning years, but without knowledge of nor interest in business or speculation, do to make sure that they and their wives will not find themselves, on the downward slope of life, in a condition of miserable destitution?

It now looks as if a plan to answer this question, in a sound and practicable manner, were in process of formulation, in the form of the establishment of a Medical Arts Home (or a series of them), where members, more than sixty-five years old, of the medical and allied professions, could, by the payment of a lump sum not too impossibly large, be assured of a comfortable and congenial retreat where they might spend the rest of their days in dignified comfort, free from financial cares and worries.

Old People's Homes are not untried or visionary. Enough of them, of various types, are in successful operation to prove that the idea is workable. If the physicians of this country will get behind a proposition like this in sufficient numbers, it can become a reality within a few years.

In the advertising pages at the back we are giving space to an announcement of this undertaking, because we think it is a worthy project, but we withhold specific indorsement until it is more fully developed. Look up the announcement and write to Counsellor Phillips telling him what you think of the plan.

The wise man seeks little joys, knowing that life is long and that his quota of great joys is distinctly limited.—*Little Journ. for Physicians.*

Proctology

THESE are times when every physician needs to be making use of every practicable and ethical method for increasing his usefulness to his patients, and thereby his income.

It has long seemed that one of the most fruitful fields, especially for general clinicians, has been unwarrantably and too long overlooked. An immense number of people are suffering from diseases and disorders of the rectum and colon; but because most physicians have failed to prepare themselves to diagnose and treat these conditions acceptably, many such patients have fallen into the hands of charlatans or are continuing to suffer unnecessarily, because their family doctors have been unable or unwilling to help them.

With this idea in mind, we have arranged

to publish in this Journal a regular department, dealing with diseases of the rectum and colon, so that our readers may inform themselves regarding the methods by which, with a reasonable amount of study and practice, they can add materially to their remunerative practices, with a minimum expenditure for additional equipment.

This new *Department of Proctology*, under the able associate editorship of Dr. William A. Hinckle, of Peoria, Ill., will make its first appearance in our April issue, and we shall welcome constructive comments and suggestions as to how we can make it of the utmost pratical value to our readers.

WORK is the only capital that never misses dividends.

Dental Examinations for Life Insurance

IN view of the importance which the condition of the teeth has come to assume in the evaluation of disease states (even though "focal infection" may not be the "bogey-man" it was a few years ago), it is rather surprising that the life insurance companies are not demanding a more complete and detailed dental examination than is now generally required as a preliminary to the purchase of one of their policies.

Of course, the average physician could not make such an examination, and that would require a separate professional certificate, with a separate and additional fee. Perhaps that is why such a procedure has not been universally adopted. If so, it really might prove to be a penny-wise and pound-foolish policy, because the premature payment of one good-sized claim, due to a condition which could have been recognized by a competent dentist, would pay for a great many dental examinations.

Unfortunately, the bulk of the population has not yet been "sold" the idea of periodic health audits (and this is largely the fault of the medical profession), and the only time when the doctor sees them when they suppose themselves to be healthy, is when they want to take out life insurance. It is, therefore, important that examinations for this purpose should be as thorough as possible and that the applicants should be informed of any physical defects discovered. Such really valuable studies will, however, be impracticable, until the insurance companies cease to exploit the physicians by demanding that they make these examinations for a fee so paltry that no busy man can afford to carry them out in any other than a superficial way.

When, as and if dental examinations for insurance become the order of the day, the medical insurance examiners should not tolerate a reduction of their fees, in order that the dentist may be compensated for his. This work should be done *in addition* to what is now being carried on.

Incidentally, it might be well to give some thought to what (if anything) can be done to convince the life insurance companies of the economic soundness of paying fees which are large enough to buy a *thorough* examination by a competent medical man.

NEXT MONTH

Dr. Burton Haseltine, of Chicago, will discuss a subject of interest to almost all physicians —the ionization treatment of hay fever, giving reasons and indications.

Dr. G. A. Rau, of Wisconsin, will explain, in detail, how to add dollars to your income by treating corns, warts, moles and similar lesions successfully.

Dr. Henry R. Harrower will give some sound ideas regarding the relation between the adrenal system and infectious diseases.

COMING SOON

"The Care and Feeding of the Premature Infant," by Harry Apfel, M.D., M.Sc., of Brooklyn, N. Y.

"The Doctor in War," by Col. G. P. Lawrence, Med. Res. Corps, U. S. Army, of Westerville, O.

LEADING ARTICLES

Geriatrics and Geriatric Nursing*

By Ralph St. J. Perry, M.D., LL.D., Minneapolis, Minn.

BY geriatrics and geriatric nursing is meant the medical treatment and nursing of old folks, a matter which seems to have been greatly ignored by those engaged in the care of the sick. This may be due to the fact that the average old person is not looked upon as an invalid needing sick care. That the aged are neglected in this detail of their life is painfully evident. When younger, I used to sympathize with those old folks who were bedridden or who belonged to the "shut ins." Having myself now passed the age of seventy, having acquired some of the perquisites of an alleged "ripe old age" and having had forced upon me some of the penalties of senility, it is realized that there are hundreds of aged people who are not bedridden or shut in, are not totally disabled, yet are incapable of taking complete and proper care of themselves and who need a certain amount of nursing care or attention. Those who attend to these needs are often termed "companions" rather than nurses.

Everyone who has come in contact with old persons has noted that certain changes have taken place with the onset of senility. Even a cursory observation will disclose changes in the skin, eyes, bones, abdominal viscera, genito-urinary organs, muscular system, nerves and mental condition.

Most of these changes are due to the so-called "wear and tear" upon the body and are to be found in nearly all individuals. The advent and degree of these changes are undoubtedly influenced by climatic conditions, by exposure to heat, cold, rain, snow, wind, dust, etc.; by habits of eating and sleeping; by use and abuse of the body and its functions; by work, play and a hundred and one varied factors with which the individual comes in contact during a lifetime.

One of the earliest senile changes in the body and one not often recognized in its beginning, is arteriosclerosis or hardening of the blood vessels, in which the tissues of the arteries become impregnated with lime salts and the arteries take on a whipcord feeling; in fact, some of the larger arteries, such as the femoral, radial, tibial and axillary, may resemble clay pipe stems. The arterial walls become thickened, their caliber is diminished and as a result there is a lessened blood supply to the various organs. In the skin this is manifested by lessened secretions, with consequent dryness, hardness or harshness, loss of subcutaneous or "baby" fat, with wrinkling and changes of color. This loss of subcutaneous fat eventually results in the formation of pendant jowls or wattles, of prolapsus or overhanging of the breasts, bagging eyelids, wrinkled backs of the hands and other well-known signs of senile atrophy.

Skin Changes

This sclerosis, also called atheroma, occasionally leads to a breaking down of the arterial walls, with small subcutaneous hemorrhages, a condition called senile purpura, manifested by purplish spots which gradually change to a brownish color. These changes in the skin tissues often give rise to perversions of sensation and we find old persons frequently suffering from pruritus, formication, etc.

Warts are common in elderly folks and are usually of the flat variety. Also we often find a senile keratosis, usually pigmented. Warts seldom cause any trouble. The keratosic spots usually itch and, if scratched too roughly, may break down and bleed. Any wart, mole, small sore or ulcer or similar skin condition, if subjected to prolonged irritation, is very apt to take on malignant changes and result in a skin cancer. Such formations should be left alone and not subjected to treatment to remove them. In the vernacular, *don't monkey with them.* Should a skin cancer develop, have the patient consult a competent surgeon immediately, as loss of time in these cases may mean loss of life. If seen early, most of these cases can be cured by radium or the x-rays. If treatment be delayed until there is glandular involvement, the end too often is a fluttering crepe on the front door.

Pruritus is quite common in the elderly, especially if diabetes is present. Should the itching be limited to the head it might be well to search for lice or other parasites, such as fleas, scabies, etc., which may have migrated

*A lecture delivered to the student nurses and alumni of the Vocational Hospital, Minneapolis, Minn.

from pets or from visiting children who have snuggled up to their old friends. Itching of the lower extremities is quite common in cold weather and is best relieved by warm, dry applications, such as hot blankets and hot rubs. As the skin is frequently too dry, it is well to apply coconut oil, vaseline or benzoated lard, olive oil, carron oil, etc. Sponging with hot water to which a little salt, bicarbonate of soda, (1:20), tartaric acid, (1:30) or vinegar, (1:20), has been added may be helpful. Unusually severe cases call for medical treatment and the family physician should be called upon.

The senile, because of their failing mental faculties and the dulling of their special senses, are very apt to neglect their skin and develop habits of uncleanliness. Therefore, those in charge should pay especial attention to matters of personal cleanliness, as a dirty skin may soon become a diseased one. The first evidence of inflammation or irritation should be given attention. Perfumed and colored soaps, while attractive, are no more effective than plain white coconut, olive or palm oil soaps. Personally I do not think it advisable to add carbolic acid or lysol to water used for washing, as the risk of burning and poisoning is great and their use is of no especial benefit. Should eczema or other skin disease develop, the patient should at once be taken to a doctor for treatment.

Exercise and Occupation

The senile person, who is enjoying as good health as can be expected for one living in a breaking-down body, needs recreation, exercise and work. It is an old story that idle hands soon find mischief. Present-day civilization has multiplied many times the forms of recreation available to the sick. What with reading books and papers printed in large type and with radios and phonographs available at any hour of the day or night, no senile person need lack for entertainment in his own room. Auto rides, movies and other entertainments await his pleasure. Find out what kind of entertainment the person enjoys and do your best to supply the demand.

The question of alcoholics and tobacco perennially bobs up, and my advice is for the nurse to pass the responsibility along to the attending physician. If the doctor orders the patient to have a glass of beer, a drink of wine, whiskey or other liquor, the nurse should obey his orders. A pipe of tobacco or a chew of old-time plug often affords consolation such as no other pleasure can. If your patient has enjoyed a little nip or a pipe through the years of a long life, there should be some very strong reasons for depriving one of that wee bit of solace in the declining years, which nature has decreed shall be spent largely in the lonesomeness of senility.

The welfare of the aged person calls for a certain amount of exercise, active if possible, otherwise passive. The simplest form of exercise is walking, allowing the individual to regulate the pace to suit his desire and ability, from an easy going stroll to the brisk stepping induced by the exhilirating air of a frosty morning. Croquet and other of the less strenuous out-door games will be found useful in affording an hour or so of entertaining exercise. Whatever form of activity may be carried on, be careful to keep your charge in restraint, lest temporary enthusiasm leads to over-doing and exhaustion.

In an institution or home for old folks it will be found much easier to amuse those living therein. As a rule they have no worries over their future and, with few family ties to bother them, they can lead a carefree existence at the expense of relatives or the indulgent tax payers. With plenty of companions at hand they can play games of all kinds, gossip and discuss personal and public affairs freely, either harmoniously or discordantly.

Work is something which should not be neglected. Call it work or occupational therapy, the psychic effect of something to do is wonderful, especially in those cases where the patient is inclined to be melancholic. Many a decrepit man, who looked upon occupational therapy as ridiculous child's play, has been delighted by getting a job at easy but "honest to goodness" work. For years it has been recognized in railroad circles that an engineer who is taken from his engine and retired because of old age mopes about the round-house for a few months, and then dies of a "broken heart." The strain and worry of enforced idleness is too much for the old man, his resistance becomes broken down and ere long some intercurrent disease nips him off. Had the old man obtained a light job of some kind, to "keep his mind off his thoughts," he would probably have lived for years.

One great advantage about exercise and work is that they keep the patient out of bed—a point of great value in caring for the aged. The idea of keeping an old person in bed merely to get him out of the way, too often begets a mental condition which encourages the patient to become a prematurely bedridden invalid and eventually a nuisance, to be passed on to a nurse or some institution. Many old people look with horror upon bedridden disability as a death-bed existence, therefore any effort to keep them ambulant, or at least in a chair during the day, is worth trying. Constant confinement in bed or in an invalid's chair eventually causes loss of hope of recovery, lack of interest in personal affairs and affairs in general, carelessness about body functions, mental hebetude, and,

in the end, senile dementia and premature death.

The physician and nurse should encourage the patient to get out of bed, to sit up in a cushioned chair, then to walk a few steps, with help at first, then alone, and almost before one realizes it the bed has become a reminiscence. This is especially true in the case of those surgical operations which would not put a younger man to bed. The fact that he cannot stand what he used to, that he is in bed for something that others endure while up and about, is often the first intimation of approaching senility and the patient conjures up visions of a decrepit old age with a cane, crutches, wheel chair, lounge and eventually a bed with a rubber blanket. Right there is where encouragement is needed to abort this sequence of perverted thought, and the realization that he can stay out of bed, that he can move about "under his own power," acts as a stimulant to recovery and helps to throw off the threatened incubus of a helpless old age.

A brief review of some of the phenomena of senility may not be amiss. Deafness is one of the first to be noted, and may be due to catarrhal trouble in the eustachian tubes, to nerve disability or to impacted cerumen. To determine the exact cause, an examination should be made by a specialist and the future care or treatment followed out as directed by the examiner. The commoner eye troubles are defective vision, which can be corrected by lenses; chronic conjunctivitis, to be treated locally; and cataract, which requires surgical treatment. Obesity comes to some people with the advent of old age, and if it be a family characteristic it is best not to worry over it; just put the patient on a simple diet, sufficient to meet the needs of good health, and be satisfied therewith—no drugs, no starvation, no complicated special diet.

Diet

Speaking of diets reminds me that there should be regularity of meals, the food should be simple, well prepared and tastefully served. This means individual attention and, in institutions, calls for the employment of from two to five assistant cooks. Meats, fowl and fish should be properly prepared for cooking, "done to a turn" and served in small pieces. This same suggestion applies to breads, vegetables, soups and drinks. The plate can be garnished with a bit of parsley or other plant, to add to the attractiveness of the viands. It is far better to have the patient ask for a second portion than to have him turn away in disgust from an overheaped, mussy dish of greasy or watery food.

Eating between meals may be permitted and even encouraged, if the patient shows the need of additional nourishment. Sometimes I think it advisable to adopt the European custom of five meals a day for the aged—morning coffee and rolls upon waking or at 7:00 A.M.; breakfast at 9:00 A.M., of eggs, toast or cereal, with a glass of milk. The cereal can be served with a small sprinkle of salt instead of sugar and many will consider it more palatable. At noon comes lunch; at 4:00 P.M. tea is tendered the patient and is usually acceptable, as it is generally nothing but a light lunch of cold meats, with tea or coffee. Dinner comes at seven o'clock, is the chief meal of the day and may include everything from soup to nuts, according to the habits of the individual, the digestive ability and one's inclinations. Supper is served at 10:00 P.M., for those who are awake and in a receptive mood.

Do not forget that the average person begins to go down hill physically after forty-five, that the waste exceeds the upbuild and there is greater need for repairs, hence the demand for a greater amount of nourishment. Anyone who has experienced severe hunger knows the feeling of weakness, debility and the constant gnawing sensation, with irritability and inability to concentrate the mind on any work. If these phenomena appear in an adult, what can be expected from a senile person whose resistance is breaking down?

Experience has shown that protein foods are required to build up the body and that, in old persons, certain elements are eliminated from the system more rapidly than in adult life and special effort must be made to maintain the balance. We know that meats, eggs and milk are rich in proteins; therefore, these foods should be supplied in abundance. Lean meats can be cooked in almost any way except fried. Pork, however, should be sparingly used, as it is hard to digest. It can be reserved for the winter months, when there is need for a little more fat food. If your patient has poor teeth, the meat can be run through a meat grinder.

Ground, cooked meats can be mixed with gelatin, to which a flavoring sufficiency of lemon juice or vinegar has been added, to make a meat jelly or aspic, which is chilled in the refrigerator and, when "set," sliced for serving. Aspic can be given a dozen different flavorings to make it more palatable, or garnished with berries, sliced small fruits, lemon or orange, fresh herbs, etc., to increase the appetizing appeal. Gelatin in any form is an advantageous addition to any menu for an aged person. For recipes, write to any gelatin maker.

Fresh eggs can be given cooked in any way the patient likes. I do not believe that an egg soft fried, "sunny side up" in butter, is harmful. When eating in a strange place call for soft-boiled eggs in the shell, as such an egg must show itself young and innocent when opened at the table; scrambled eggs

and omelets may be made of "any old eggs" and their delinquencies muted by condiments. These were the kind words spoken to me years ago by the friendly chef in a "short order joint".

Milk is man's natural food; starting with mother's milk, when a few hours old, and passing on to cream, butter (with bread), ice cream, a hundred kinds of cheese, kumis, custards and junket. There are thousands of people who never heard of junket and other thousands who have never tasted it. I firmly believe that St. Peter will wipe several black marks off of my tally sheet because of my having introduced hundreds of families to junket tablets and rennet. Every old person should take a quart of milk a day, in some form or other—an amount which looks formidable for daily consumption, yet is easily cared for when taken assorted in the various forms mentioned above.

Just a word about water. Most drinking water is hard and full of lime salts, which abet in the sclerosis of arteries; therefore, use a limeless drinking water for the aged.

Vegetables and fruits are an essential to the diet, as they contain mineral salts, mild acids, oils and fats. They are the principal sources of certain vitamins which maintain health.

In feeding your patient, see that the bed or table is free from litter, such as books, papers, wilted flowers, etc.; arrange the pillows and covers so that the patient will be comfortable while eating and see that the tray and table are conveniently placed. Remove from view all objects or sights tending to interfere with the appetite. Have the patient go to the toilet before meals when possible.

Many old persons prefer to eat alone rather than have company to stare at them while eating. In a great many instances it is advisable not to tell the patient what is going to be served; just have each meal a pleasant surprise. If the patient is on a diet, the nurse should adhere strictly to the doctors' orders. If desirable and suggested, the doctor will usually allow sufficient variation in the preparation of foods to do away with that monotony which destroys the appetite. Menus are affected by seasons, markets, fads, idiosyncrasies and monetary considerations and many obstacles will be met which the nurse must overcome as best she can.

Physical Complications

The genito-urinary system undergoes marked changes in senility; the woman passes through the menopause, with subsequent atrophy of the generative organs and sterility; the man becomes impotent and suffers enlargement of the prostate gland. Many old persons develop sexual perversions, and must be closely watched lest embarrassing situations develop. Rheumatism, gout, diabetes, asthma, bronchitis, gangrene of the toes, paralysis agitans and bladder inflammations are quite common in the aged and must be handled according to the symptoms disclosed.

We find that many persons, who acquired syphilis in the days of their virility, develop cerebro-spinal symptoms some twenty to thirty years later and become the victims of tabes dorsalis or paresis. They also occasionally show a dilation of the aorta. Usually these cases grow progressively worse and sooner or later die. In any disability of obscure origin, occurring in old persons, it is well to secure a Wassermann test, as many will try to conceal a syphilitic infection acquired in youth and others may not know of having been infected.

Mental Condition

The mental condition of the aged may vary from a perfectly clear mentality, through "second childhood" to senile dementia. An early evidence of mental disturbance is loss of memory of recent events. It is peculiar that old persons can recall vividly events which occurred in their childhood, and yet entirely forget important things said or done within a few days previously. Such persons often carry memorandum books as necessary adjuncts to their daily work, but even these eventually become useless as the mental infirmity increases.

We find that many old people suffer from brain fog—a condition of mental exhaustion which develops during the performance of a task involving mental activity. For example, a lawyer, minister or teacher will start to make an address upon some subject with which he is familiar. At first the words come freely and the speech is coherent, but as the address continues there comes a tendency to wander from the subject, the speech may become incoherent and rambling and there follows a breakdown, necessitating the withdrawal of the speaker. Another example is found in an old person who writes a letter starting out with clear lucid statements, later introducing erratic and irrelevant matter and ending in a jumble of words of no intelligence whatever. After a few hours of rest or sleep, the brain appears to become restored to its normal function and everything is apparently all right. But this condition of brain fog progresses adversely and is merely premonitory of the senile dementia, which comes later.

In some cases the perverted mental condition may be precipitated by intestinal toxemia following aggravated constipation (either in degree or duration), and upon removal of the cause there is a clearing up of the mentality. Even at that, the acute condition stands as a warning of a condition that will reappear, under provocation, as a

chronic disability. These attacks are especially noticeable and embarrassing in aged distinguished persons, who are frequently called upon to make addresses on special topics, after-dinner talks and similar short bits of oratory, and special efforts should be made to protect them from individuals and committees who come soliciting such services. Such occasions, intended as an honor to the "old and respected citizens," are too apt to end in disagreeable episodes.

Elimination

Those in charge of patients showing a tendency to mental aberration must be on the constant lookout for evidences of insanity and, should any such be noted, steps should be taken for their proper control. Many of these cases are aggravated by chronic constipation and may be relieved by removing the cause. It has proved expedient to change the medicine used every three or four weeks, as the system learns to tolerate and ignore the action of a drug continuously administered. For years I have advised the changing of the remedy on the first of each month, using six remedies in rotation, as follows: Compound licorice powder; cascara evacuant; phenolphthalein; calomel; Hinkle's pills; and a pill made of caroid and bile salts.

Compound licorice powder, a teaspoonful in a little cold water, causes one or two bowel movements the next day, is pleasant to take and works easily; phenolphthalein is usually given in tablets; calomel, one 1/10 grain tablet every hour until twelve have been taken; the Hinkle's pills and caroid and bile salts tablets are standard preparations and can be secured at any pharmacy.

Remember that foods affect the stool; that iron preparations cause black or slate-colored stools, and milk foods stools which are yellow or grey; that red blood is most commonly due to hemorrhoids and that the black, tarry stool is indicative of gastric ulcer or carcinoma.

One of the most important duties of the nurse is to note and report any changes in the condition of the patient. Diseases make themselves manifest by various indications called symptoms. Symptoms may be objective (those which are evident to the senses of the observer) and subjective (such as may be felt and complained of by the patient). It is, therefore, incumbent upon the nurse to note and report any new objective symptoms carefully and to make inquiry about and report any new complaints the patient may make.

The nurse should, on taking charge of a patient, make an inventory of the size, shape and color of the several parts of the face and head; the expression of the eyes and mouth; peculiarities of appetite and thirst; habits in sitting, walking and lying down. Defects in speech will appear under certain conditions and should be noted and reported to the doctor at once; so, too, with changes in temperature, perspiration, breathing, etc.

Do not become alarmed too easily or become confused and misinterpret symptoms or complaints. For instance, a person may feel cold and yet have a normal temperature, the trouble really being insufficient clothing or bedding and readily remedied by dressing more warmly or by putting more covers on the bed. Another person may have a high fever and not feel the least bit warm. I remember, on one occasion, I myself had a temperature of 105.5°F. and felt "as cool as a cucumber". Believing that the thermometer was at fault, it took the readings of three different thermometers to convince me that I had a fever.

Bed Sores and Cramps

Two chronic conditions which bother bedridden senile patients are bed sores and leg cramps. For the former, the best treatment I have found in half a century of practice consists in daily cleansing of the sores and applications of an ointment composed of:

℞

Thymol Iodide	℥ i	4.00
Balsam Peru	℥ ii	64.00
Ol. Ricini	℥ ii	64.00

Met. Sig.: Apply locally.

Should there be a syphilitic factor in the case, bismuth formic iodide is substituted for the thymol iodide.

For the leg cramps, give the patient ten or fifteen drops of dilute hydrochloric acid, in a little cold water, after each meal, along with a morning dose of Lilly's Kaomin. It seems that nearly all of these crampy senile individuals suffer more or less from constipation and colitis, and the kaolin in the Kaomin relieves them. Rubbing the legs with methyl salicylate also affords relief—partly physical; largely psychic.

By way of closing, let us go over a daily routine of one of our patients.

Daily Routine

Being senile he runs true to form, wakes early and demands attention. The morning toilet consists of washing the face and eyes, combing and arranging the hair, cleansing the nose and throat, brushing the teeth (natural or artificial) and rinsing the mouth. There are hundreds of dentifrices, all of them good and each one "the best," but the only preparation I know of which will satisfactorily cleanse a denture (plate or bridge) is Denwin, a soluble powder made by the Linwood Laboratories, of Minneapolis, Minnesota.

At seven o'clock comes coffee and rolls, followed by a sponge bath and a shave, possibly an alcohol rub. Usually a shaving

cream is less irritating than soap and brush, and a safety razor is better than the old-style blade. Next comes the morning newspaper, the radio news, the early mail, etc. Breakfast at nine; then books, magazines, a walk or ride until noon, when we stop for lunch. After lunch there is the early afternoon for a few callers or a little business or outdoor sports. Tea comes at four, followed by a short nap of an hour or so. Then the afternoon toilet, more callers and a walk or ride. Dinner at seven, then the evening paper, the radio, callers, cards, the cross-word puzzle and to bed not later than nine. Should he have the habit of sitting up until ten or later, he can have a light supper at ten.

602 Nicollet Avenue.

Septate Uterus and Vagina with Double Cervix

(A Case Report)

By Edmund D. Levisohn, M.D., Chicago

ANOMALIES of the uterus have frequently been reported in the literature, the most common being the bicornate uterus with a single cervix. In reporting this case I am only adding one more to the many already reported, but it is of interest from the standpoint of diagnosis and from the fact that the anomaly was overlooked for many years, in spite of numerous examinations by a large number of physicians.

Report

Mrs. R. B., age 40 years, married, was referred to me on April 23, 1934, complaining of excessive menstrual flow for the past year, requiring eight to ten pads daily and continuing for about a week at a time, with many large blood clots. Her last period, however, started six weeks previously and, with the exception of a day or two, she had been flowing constantly since then. During this time she has been having severe cramps and pains in the right lower abdomen, and at times she thought she had some swelling in this area.

The patient had been married 15 years, but had never been pregnant. She stated that coitus had always been painful. Her periods began at the age of 13 and were very irregular, the duration being from 3 to 7 days and the intervals 2 to 8 weeks. She never had any vaginal discharge.

Eleven years ago and eight years ago she was curetted, and on both occasions she was told she had some kind of obstruction which interfered with proper completion of the operation. Other past history and family history were essentially negative.

Physical Examination: A well nourished and well-developed female of about 40 years; color rather poor; height, 5 feet 4½ inches; weight, 129 pounds; temperature, 98.6°F.; pulse, 72; blood pressure, 120/70; hemoglobin, 70 percent; red cells, 3,150,000; leukocytes, 7,200. Her eyes, ears, nose and throat were normal; thyroid gland not enlarged; mammary glands very small; heart and lungs normal; abdomen flat, showing no palpable masses, but some tenderness on pressure in the right lower quadrant; no rigidity of the abdominal muscles.

On vaginal examination, the finger slipped over a fold of tissue before encountering the cervix, which was normal on palpation. The fundus uteri was difficult to palpate, on account of marked retroflexion. Rectally, the fundus was easily palpated and found to be smooth and somewhat larger than normal. No abnormal condition was palpable in the adnexa.

Upon introducing the speculum, a normal-looking cervix presented itself, with a drop of blood-tinged mucus protruding from the os. The speculum was turned through 90 degrees, and a fold of mucous membrane in the vaginal vault, which extended obliquely from the cervix downward and to the right (patient on her back), presented itself to view. When this was pushed aside, a second cervix was disclosed, with a small polyp projecting from the os, accompanied by a slight bloody discharge.

At the next visit the polyp was removed from the cervix, a small catheter was introduced into each cervix, Lipoiodol was injected, and a roentgenogram taken. This showed the catheters within the os, but failed to outline the uterine cavity. A diagnosis was made of double cervix and probable bicornate uterus. The patient was advised to undergo a hysterectomy.

On May 5, 1934, the patient was operated upon at the Illinois Masonic Hospital, under general anesthesia. A midline incision was made. A chronically inflamed appendix was removed. The uterus was markedly retroflexed. Complete hysterectomy and bilateral salpingectomy was done in the usual manner, and the abdomen closed. The vaginal septum was then dissected out and the denuded areas sutured. The patient made an

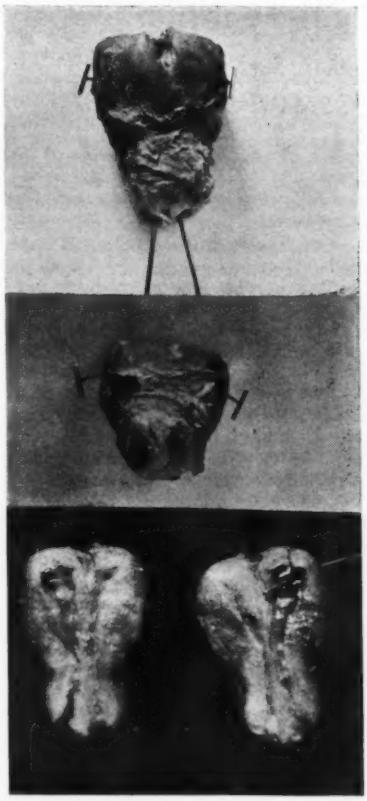

Fig. 1.—(Top) The Removed Uterus, Showing a Probe in each Cervical Canal; (Middle) View Showing the Two Ora of the Uterus; (Bottom) Uterus Sectioned Sagittally, Showing the Two Cervical Canals and Uterine Cavities.

uneventful recovery and left the hospital ten days later.

Examination of the removed organs disclosed a uterus slightly larger than normal, with two separate and distinct cervices. A probe passed easily through each os into the uterine cavity, which was found divided into two separate parts by a septum. Each uterine cavity communicated with a tube. The ovaries had been found normal at operation and were not removed. Both uterine canals presented polypoid degeneration of the epithelial lining.

Comment

It is surprising how easily marked anomalies of the uterus can be overlooked. Many of the reports in the literature indicate that the anomalies described were not suspected until pregnancy and labor set in. Others were accidentally discovered during operations.

This patient had been examined, in the past, by eleven different physicians, and on two occasions had been curetted, without her anomaly being discovered. An early diagnosis, followed by the proper plastic operations upon the uterus, might have put the patient into such physical condition that she might have had children. At this late date, the only operation indicated was hysterectomy.

In closing I wish to thank my associates, Dr. I. L. Sherry and Dr. W. H. Gilmore, for their corroboration of my preoperative diagnosis and their kind assistance in making this interesting report.

115 W. North Ave.

GOVERNMENT SPENDING AND BOLSHEVISM

For the past decade or more we, as a people, have rushed wildly ahead increasing governmental expenses. We have forced the government—and this applies all the way down the line from federal to local—to engage in activities which are not the functions of government and so, of necessity, weaken our whole social structure. We have demanded this or that expenditure and, for some unaccountable reason, have assumed that we were paying nothing when we voted a bond issue. As we have stated several times, the fault does not lie with those elected to office and who voted the appropriations, but instead to well organized minorities which have insisted upon the expenditure, usually in the name of "public improvement" or "social reform."

This much is certain, unless steps are taken to drastically reduce the cost of conducting government—local, state and federal—and this mighty soon, the next reform will be to wipe out the private property right completely (which is Bolshevism), and when that happens, if it does, your nicely improved home or farm which, because you could borrow money, has been put in such shape that it enables you to make a living, will no longer be yours. You lose and the fellow to whom you owe the five thousand dollars loses with you.—COMMITTEE ON AMERICAN EDUCATION.

Practice of Surgical Technic

(For the "Once-in-a-while" Surgeon)

By Geo. C. Croston, M.D., Sapulpa, Okla.

THE basic principles of psychology—the science of human behavior—are founded upon certain fundamentals, among which are:

1.—All human achievement is brought about by some form of bodily activity.

2.—All bodily activity is caused, controlled and directed by the mind.

3.—The mind is the instrument we must employ for the accomplishment of any purpose.

Everyone who succeeds in the arts, sciences, athletics, oratory, or what not, must first practice and practice and *practice* for the task or competition that is in the near future. This being so in all of the other lines of endeavor, why should the surgeon not do likewise?

Look at the practice it takes for a baseball team before a game. See the work-out a pugilist goes through for weeks and weeks. Follow the rounds upon rounds of practice a successful golfer puts in before a stiff competition. Basketball teams, football teams, hockey teams, professional tennis players, practice, practice, *practice*, all striving for efficiency! Watch a Fritz Kreisler or an Efram Zimbalist, with his wonderful technic. They were not born that way; it didn't just happen; it took hours and hours, practically all their lives, of practice, practice, *practice!*

The amount of surgery the just-below-average surgeon has to do and does is not sufficient to give him that fineness of skill, of technic, of accuracy, that he should possess. Surgeons who do not operate daily, or at least weekly, should practice "on the side," to obtain this necessary skill.

I find that, by indulging in this practice daily for a few weeks and then twice a week thereafter, one can maintain a degree of speed and accuracy sufficient to satisfy the most critical observer or patient. I usually use some half-hour close to the noon time for this practice.

Seclude yourself in your private office. Place two pillows (small ones preferred) at one end of your examining or treatment table, under a good light. Now place an 18x32 inch towel over the pillow. Turn the proximal and distal thirds of the towel to the center, so that their edges meet. Clamp the two edges together with two large artery clamps, placing the clamps at least 8 to 12 inches apart. This aperture between the clamps, formed by the edges of the towel, represents an imaginary open incision in any part of the body. An extra clamp should be placed on both the distal and proximal folded portions of the towel, stabilizing it to the pillow.

The following items are quite sufficient for this practice:

1.—One spool of 3-cord, No. 40 machine thread.

2.—Two needles, one of medium size and full-curved, with a cutting edge, and one No. 1 Loopuyt's hand needle. Any type of needle used for skin suturing may be employed instead.

3.—One good needle holder.

4.—Two tissue forceps; one heavy and one light.

5.—One curved artery forceps and one straight artery forceps.

6.—One rubber glove.

7.—One 6-inch piece of catgut.

This practice is now indulged in, in the following manner:

A.—Practice of threading the 6-inch piece of catgut or a 24-inch piece of No. 40 cotton thread. There is a right way of doing this and a wrong way. Practice the right way!

Hold the needle, eye end distally, between the index finger and thumb of the left hand; the thread or catgut between the second finger and thumb of the right hand; steady the two hands by placing the palmar surface of the tip of the second finger of the right hand on the top nail surface of the second finger of the left hand. Now push the eye of the needle over the end of the gut; push the end of the needle down almost between the second finger and thumb; then catch the end of the gut between the tip end of the index finger and the thumb of the right hand and pull it through. Do this fifteen or twenty times.

B.—Practice tying your favorite knot for five or ten minutes, to obtain speed. The one I use is the one-hand, index-finger knot, followed by tying the next one from between the second and third finger of the same hand. With this technic one should practice tying these knots for five or ten minutes, first with the right hand and then with the left. Practice until you have used three 24-inch strands of thread.

C.—Next I take the needle holder and threaded needle and sew the loose edges of the towel together, first using one type of stitch and then another type. This gives one splendid practice in handling the needle-holder and needle properly. Do this three or four times with each type of stitch used.

D.—Take a 24-inch strand of No. 40 cotton thread on the Loopuyt needle. There is a

right way and a wrong way of handling this needle. The right way is to place the needle between the thumb, index and second fingers of the right hand and push the thumb deep into the angle of the needle, with the tip of the index finger on the posterior surface of the eye piece, allowing the sled portion of the needle to ride on the radial surface of the second finger. By holding the needle taut in this position and using a supination stroke, with a partially stiff wrist action, one can handle this kind of needle very cleverly.

E.—I sometimes end my practice by tying, five or six times, a transfixion tie which, from a speed standpoint, is very important. This is done by tucking or pyramiding the towel and clamping over it an artery forceps; then passing the threaded needle through the center of this. Swing the suture around under the shank and tie with one finger; then continue around over the tip of the forceps and under the forceps to the original tie; and then tie again with the one-handed knots.

This practice does not mean that one should not visit the surgical clinics for new ideas, but I can assure anyone who will zealously practice it, that he will be a much more accurate, speedier and more self-confident surgeon after doing so for a while.

Coryza and Nasal Sinus Infections

By L. E. Grant, M.D., Detroit, Mich.

THE first thing observed when we look into the nose of a patient with acute coryza is congestion of the mucosa, more marked over the turbinates, especially the middle one. If this continues for some time or if there are frequent head colds, the mucosa becomes chronically thickened, edematous and, at times, hypertrophied, which we term, according to the times involved, acute, subacute and chronic stages.

So far as the etiology is concerned there are two kinds of acute coryzas: First, contagious, or the cold in which the infection precedes and causes the congestion; second the cold that comes from exposure or lack of resistance, in which case the congestion comes first, making a fertile field for the bacteria present in the region and producing the coryza. In either case the congestion and edema soon block the natural openings of the sinuses, preventing the free entrance of air and favoring congestion of the mucosa and an exudate into the sinus, which becomes infected, leading on to the formation of pus and subacute, and finally chronic, sinusitis.

Therefore, the aim of the primary treatment should be to relieve and prevent the return of the congestion so that the foramina of the sinuses may be kept patent. In the subacute and chronic cases, where the sinuses are already filled with an exudate and pus and the normal openings are blocked, we must reduce the congestion and edema and restore the patency of the foramina as rapidly as possible, secure free and continuous drainage of the infected sinuses, and maintain such conditions continuously without producing tissue changes which defeat our ultimate success, or have an ill effect upon other parts of the body. This we combine with a mild, non-irritating antiseptic, to destroy the bacteria on the nasal mucosa, but always remember that the medication does not reach the sinus cavities and also that any medication that irritates and produces congestion of the mucosa does much more harm than good.

In search of this ideal during the past twenty-five years I have experimented with many preparations and varying strengths of each, with various methods of application, in an effort to secure the best results at the onset of the treatment and also the best results in the more chronic cases, in which the medication has to be used continually for a long time. Of course, if there are obstructive lesions in the nose or a sinus has a chronically infected mucosa, it will not be relieved by drainage, and the proper operative treatment should be carried out at the onset.

Of the preparations experimented with, cocaine, adrenalin (epinephrin), ephedrine, synephrin tartrate and Neo-Synephrin are the only ones that have proved of real, marked value.

Cocaine in weak solution, with its very marked bleaching effect on the mucosa, was of value in making a diagnosis but, on account of its reaction on the tissues and its general systemic effect, it has a very limited place in treatment, especially that of chronic cases requiring long-continued medication.

Epinephrin came next, and I have been experimenting with it in these nasal conditions since 1907. The bleaching of the tissues is very rapid and marked, but of only short duration, and in using the stronger solution, 1:1000, it frequently produced sneezing and at times was followed by edema of the mucous membrane and occasionally systemic symptoms. After a long series of experiments I succeeded in avoiding these unpleasant reactions by reducing the strength of the solution, with an isotonic or slightly hyper-

isotonic solution, to 1:12,000 or less. This solution gave about the same bleaching effect as did the stronger one and could be used for a long time without sensitization. The bleaching effect lasted about 1 to 1½ hours.

When ephedrine was placed on the market I began experimenting with it. It was slower in action, but its bleaching effect lasted from 3 to 4 hours. The 3 percent solution produced sensitization of the nasal mucosa in a great many cases, and when this occurred it did more harm than good. I also found that, by reducing the strength from ½ to 1/6 of 1 percent with an isotonic solution, the immediate results were as marked and the cases of sensitization were reduced in proportion, and the medication could be continued very much longer.

About four or five years ago I began using synephrin tartrate, and found its action about the same as that of ephedrine and its continued effect practically the same, but without producing any sensitization, even if continued indefinitely. Its efficiency was not materially affected if the solution was reduced to ½ to 1/6 of 1 percent with an isotonic solution, and I felt that the general results were better with the weaker solutions.

About two years ago, Neo-Synephrin became available for experimentation, and I found the tissues responding to this drug in about the same time and to about the same amount of bleaching as to synephrin tartrate or ephedrine, but its effect lasted from 8 to 12 hours Reduced to about 1/40 to 1/60 of 1 percent with an isotonic solution, its effect was better, especially if used for a long time. I have used this preparation in over 2,000 cases and have seen no signs of sensitization, of tissue irritation or unpleasant effect, either locally or constitutionally. In several cases I have used it continually for 6 to 8 months. These cases include acute, subacute and chronic, all forms of nasal infection, hay fever and other forms of allergy affecting the mucosa of the nose and throat.

I still use, in certain cases, the ephedrine and synephrin tartrate solution, but in a large percent of cases I find the Neo-Synephrin much more efficient. I change the solution as the case requires. Frequently I add adrenalin, which causes quicker action, or a non-irritating antiseptic. I usually prefer Hexylresorcinol solution for this latter purpose.

Method of Treatment

For office treatment I use small cotton tampons dipped in the solution and placed gently over the congested area, leaving it in place for 4 or 5 minutes. I place these tampons with a small application forceps to avoid all possible irritation. I do not like the application made on an applicator. After reducing the congestion as much as possible, I supply the patient with the medicine and a medicine dropper, advising him to use a half-dropperful of medicine in each side of the nose, holding the dropper in the nares pointed toward the nasal corner of the eye and forcing the medicine out by a quick pinch of the rubber. This is done from 2 to 4 times daily, according to the case. The patient is requested to return for office treatment daily in acute and severe chronic cases, and less often in other cases. If they are operative cases it clears the nose for operation and after operation it keeps the nose clearer, greatly enhances drainage and aids materially in healing.

For a blocked eustachian tube and otitis media, the use of the Neo-Synephrin greatly aids in keeping the tube open which, of course, is the chief object in the treatment of the ear. I also pack the nose with the Neo-Synephrin solution before cocainizing for a nasal operation, and find much less oozing of blood; it also minimizes secondary hemorrhage.

It is useful in eyes with chronic conjunctivitis, especially where the conjunctival vessels and those of the sclera are enlarged.

Conclusions

Neo-Synephrin gives much longer relief from congestion in the mucosa of the nose than other preparations now in use.

It may be used for a long time in chronic cases, without sensitization or local irritation, and I have found no disagreeable constitutional effects.

The best results are obtained by a weak solution, reduced with an isotonic or slightly hyper-isotonic solution. (I prefer a saturated solution of boric acid.)

It has a very active influence on the mucosa of the nasopharynx in opening and keeping open the eustachian tubes when they are closed.

The effect on the enlarged capillaries and enlarged superficial vessels of the eye is excellent.

823 David Whitney Bldg.

PHYSICIANS SERVE

If all men could agree so thoroughly that their objective was genuine service to mankind as do the physicians and surgeons, the world would rapidly become a better place in which to live.—DAVID DIETZ, in *Cleveland Press.*

A Review of 500 Obstetric Cases

By Edmund Lissack, B.Sc., M.D., Concordia, Mo.

IN presenting a series of 500 obstetric cases, I wish to emphasize what can be accomplished by proper prenatal, natal and postnatal care and that proper, clean and aseptic deliveries can be performed in the lowliest homes, as well as in the best equipped hospital delivery rooms.

Childbirth, in its original design, is a normal physiologic function. The process of childbirth does not differ in the shack, in the tenement or in the best equipped home or hospital. Every pregnant woman is entitled to and should receive systematic care, supervision and treatment, from early pregnancy, through labor and the puerperium, until she is restored, as nearly as possible, to normal health.

The place of delivery, in this series, ranged from the best hospital environment, with a trained corps of assistants, down through good homes with good nurses, to the lowest and dirtiest surroundings that could well be imagined.

All the cases reported in this series were handled as follows: Each case received a complete physical examination before the confinement; from one to fifteen prenatal visits; proper aseptic natal care; and six weeks of postnatal care, plus the final examination at six weeks postpartum.

This leads us up to the question of prenatal care and when it should really begin. The answer is, that it begins in the ante-natal period, with the prevention of disease and prematurity. The prevention and development of rickets is of great importance in infancy, so it may not cause obstetric complications in later life.

In the care of an obstetric case, one should inquire into the history of past diseases and, of course, ascertain also the facts of obstetric importance. A complete physical examination should be made at the first visit. Subsequent continuous supervision is essential.

Routine observations should be made of the weight, pulse, temperature, respirations, urine and certain objective and subjective symptoms. This has been my procedure for many years, and I shall try to express the results obtained in 500 maternity cases that have come under my supervision.

Of these 500 confinements, 503 babies were born. Boys numbered 199; girls 304. Of these 500 confinements, 309 were primiparas and 191 multiparas.

Regarding presentations, I find that, of the 500 deliveries, 476 were vertex; 10 breech; 10 face; 2 shoulder; and 2 brow.

Normal deliveries occurred 445 times; instruments were used 48 times; version was performed 5 times; and cesarean sections numbered 2.

In 408 confinements no lacerations whatever occurred. Very slight lacerations, requiring no attention, occurred in 30 cases. There were 60 first-degree lacerations and 2 second-degree lacerations. In about 60 percent of all primiparas no lacerations occurred.

Episiotomy was performed twice; each time in the right medio-lateral region.

Anesthesia

An anesthetic was advised in practically all cases. Chloroform has enjoyed first rank and provided satisfactory analgesia, when administered with the oncoming contractions. It provided about the same degree of analgesia as nitrous oxide, its action being as rapid and complete consciousness returning as quickly. It is, however, used less and less lately, on account of the possible danger of late chloroform poisoning. The danger is particularly great in certain toxic conditions in which the liver tends to be involved more or less primarily. Chloroform has the narrowest margin of safety in the production of respiratory paralysis.

Ether is much slower in its action than chloroform, but it is far less dangerous. It cannot compare with chloroform as an inhalation for analgesia. It may, however, be used in the home by lay assistants, under direction, with safety. It is the generally accepted safe anesthetic for delivery by instruments and practically indispensable in the relaxation it produces for version.

Nitrous oxide has many advantages. It is very slightly toxic, acts rapidly, is easy to control, produces less post-anesthetic nausea and stimulates pain, with consequent shortening of labor. Its stage of analgesia allows cooperation of the patient while suffering little or no pain, and it may be given over a long period of time.

Nitrous oxide and oxygen was used 40 times; ether 184 times; chloroform 228 times; and in 48 cases no anesthetic whatever was used, 30 percent of these patients refusing it, and in the remaining number no opportunity to administer an anesthetic was offered, on account of either arriving after the baby was born or too late to administer it.

Of 452 anesthetics administered, 186 were complete; the remaining ones were only partial. Whenever possible, a complete anesthetic at the moment of delivery was given, in order to increase the relaxation of the perineum and to reduce the chances of seri-

ous lacerations. Ironing out the soft parts manually, with soap as a lubricant, was a great help in preventing lacerations.

Prenatal and Postpartum Care and Complications

Immediately after delivery of the placenta, each patient in this series received a dram (4 cc.) of fluid extract of ergot. This dose was repeated every three hours until eight doses had been given. A constant watch was kept on the uterus, for several hours after delivery, for signs of hemorrhage.

A careful inspection was made in each patient for any possible laceration of the cervix, vagina and perineum. Lacerations were immediately repaired and the after-care of the stitches consisted of a sterile pitcher douche, sterile pads as often as they became soiled and after each defecation and urination, and the stitches painted with 3 per-cent mercurochrome. An abdominal binder was applied immediately after delivery of the placenta.

Infant mortality: Only babies still-born or who lived less than one month are considered. Of 503 babies, 7 lived less than 30 days. Of this number 4 were still-born, 2 premature infants and 1 a non-viable miscarriage.

Threatened abortion, miscarriage and premature labor constitute a very important phase of prenatal care. Of this series, three women gave signs and symptoms of threatened abortion. They were immediately placed at rest in bed, with doses of morphine and atropine, and the children were successfully carried to a period of viability. One patient was a primipara and the other two were multiparas. Of these three premature infants, two died within a week and the other was successfully raised with the aid of an incubator.

The non-viable miscarriage, at about 22 weeks, followed an operation for appendicitis.

On analysis of the still-born babies it was found that one was due to a toxemic mother (eclampsia), one to placenta previa, and two to prolonged labor.

Still-births make up an important obstetric problem. Two classes may be considered: Those that die before the onset of labor and those infants who lose their lives during labor. The former could probably be saved by proper prenatal care. The lives of the latter are not saved by prenatal care but by better natal care.

The welfare of the mother is quite essential. It is important to know what can be done for her. Good natal care can be secured only by proper prenatal care and supervision. This method provides an opportunity to make proper and adequate preparations for the care of the mother and child during the confinement and postnatal period.

Detection and eradication of abnormal conditions in the pregnant woman will ultimately benefit both her and her child. In this series one fatality occurred, due to eclampsia.

Affections of the gall-bladder and appendix occurred. Gall-bladder disease responded splendidly to medication and no surgical interference was necessary during pregnancy. One case of appendicitis had to be operated upon, resulting in a miscarriage.

Diseases of the urinary tract were seen often. Cystitis and pyelitis were rather frequently observed. These cases responded well to treatment but, in order to obtain the best results, treatments must begin early in the pregnancy and be continued to as complete a cure as possible before the termination of the pregnancy.

Oral infections were common. Proper dental care during the prenatal period eliminated many untoward effects. In this respect we are extremely fortunate, in this community, in having splendid dental cooperation.

The correction of a retroverted uterus was required once.

Pelvic deformities are extremely rare in this community. Recognition of small pelves and oversized babies, as well as careful histories of previous labors, are of great assistance in determining the conduct of a case beforehand.

Careful instruction, especially in printed form, of the mother as regards the mode of life, personal hygiene and the care of the breasts and genitals, is quite essential.

This series, which covers a period of fourteen years, is unmarred by a single case of puerperal infection. It has been aptly stated that, regardless of the surroundings in which a baby is born, if good, reasonable care is used and Nature is allowed to do her part, the odds are decidedly in favor of a satisfactory outcome.

One set of twins and one set of triplets are included in this series. The twins were unioval, with one chorion, two amnions and one placenta. Both were boys. The triplets were all girls.

I shall briefly review a few of the complications encountered during this series of deliveries.

Breech presentations numbered 10, and these were largely "simple breech" cases with legs flexed on the anterior surface of the body. One delivery was complicated with stricture uteri, due to a contraction of Bandl's ring, causing considerable delay in the delivery of the after-coming head.

Six (6) of the 10 face presentations were delivered normally and 2 with instruments. Two were persistent mento-posterior presentations. In these two cases the face failed to engage at the inlet and conversion into a

vertex presentation was called for, followed by instruments. Podalic version was performed in two cases.

Shoulder presentation occurred twice. Podalic version was performed in both.

There were two brow presentations, one a right fronto-position, showing a tendency towards spontaneous conversion by deflection to a right mento-posterior position. Converting this presentation into a vertex, a left occipito-anterior engagement was secured and delivery was normal. The other brow presentation was a left fronto-anterior. This was a slow, tedious case. The head was thoroughly impacted and it was decided to leave it alone. The baby was small and was expelled normally in due time.

Under the heading of toxemias, two cases of eclampsia occurred. One case had many convulsions before aid was summoned. A light anesthetic was given for manual dilatation and delivery. The child was still-born. The mother died of shock twelve hours later. Cesarean section was considered the best method of delivery in the other case, which was complicated by an undilated and rigid cervix. The baby was born alive and the mother made an uneventful recovery.

No postpartum hemorrhages occurred in this series. Ergot was given routinely in every case, one dram (4 cc.) being given every three hours, for eight doses, beginning immediately after the delivery of the placenta.

Prolapse of the cord occurred once and also placenta previa once.

There were 5 podalic versions: one for a vertex position complicated with a prolapse of the cord; two for the correction of shoulder presentations; and two for face presentations.

Two cesarean sections were performed. One was considered the best method of delivery in a case of eclampsia complicated by an undilated and rigid cervix. The other indication was for pelvic contraction. The conjugate vera measured 7.5 centimeters.

Of injuries to the baby, other than slight bruising from instruments, etc., there was one case of cephalhematoma. This swelling was over the right parietal bone and was limited by the suture. It appeared on the first day and I attributed its cause to pressure. It was soft but without fluctuation, existed for fifteen days and did not break down and suppurate, but was gradually absorbed. Compression was used.

Childbearing should be a health-giving and not a health-impairing function. Proper prenatal, natal and postnatal care will assure the former.

Cutaneous Complications of Gonorrhea

By Winfield Scott Pugh, M.D., New York City

IN a long experience with the treatment of gonococcus infections, it has gradually become more and more evident to me that, if gonorrhea is not always a systemic disease with a local manifestation in the urethra, it is so at least in many instances. Many authors of note deny this and I have for a long time striven to agree with them, but in vain. I believe that many are now modifying their stand, as is evident from some of the contributions to the literature in the past few years. W. F. Campbell, in 1908, stated that he was convinced that gonorrhea was a systemic infection, and more recently, Thom and Aronstam have emphasized this point. Among European students, Luys and Picker notably are of this opinion.

Campbell tells us that there is not a single organ which has not shown gonorrheal involvement, and this coincides closely with my own observations in the past twenty-four years. In Europe one hears considerably more of the extra-urethral manifestations of gonorrhea, because the disease is regarded there as of much more interest from a medical standpoint than it is here. For some reason, probably our pseudo-puritanism, the American physician does not like to have his name associated with the treatment of this disease, so that we are inclined to slip over many points that are of very great interest in this infection.

Of the complications of gonorrhea, less has been written on the skin lesions than on any other extra-urethral manifestation. Aronstam believes that gonococcus invasion of the skin may be divided into two classes: First, that due to direct involvement of the cutaneous surfaces by the gonococci; second, that which may be ascribed to metastatic influences remotely situated from the seat of the original disease. The former he regards as a focal infection per se; the latter as an efflorescence or exanthem. In 1912 I reported an interesting series of seven cases which had been observed up to that time. These cases belonged to the erythematous and purpuric types particularly; and since reporting these I have observed several cases of the socalled *keratodermia blennorrhagica* or, as the French (particularly Jeanselme, Jacquet, Robert and Chauffard) call it, *cornu-cutanee*.

The classification of these writers is particularly good, grouping items as follows:

1. Erythemas which closely imitate measles or scarlatina.
2. Purpuric types.
3. Gonorrheal keratosis.

All of these types have been sufficiently studied to establish them on a firm basis. It is my opinion, however, that abscess should be grouped in the above classification, although the cases reported are quite few and far apart, most of them in Europe. Luys quotes those of Sahli, Lang, Paltauf, Horwitz and Cassel, as of particular interest. The case studied by Cassel is noteworthy, as it was in an infant who, shortly after birth, developed gonorrheal ophthalmia, gonorrheal rheumatism and an abscess of the back, from which gonococci were obtained in pure culture. It is not my intention to discuss the various skin lesions, but to report two interesting cases of abscess and a papulo-pustular lesion that have come to my attention recently.

Case Reports

Case 1:—C. A.; white; age 24; native of the United States; housewife.

This patient reported to me complaining of a slight vaginal discharge which had been present for about one month. Examination revealed a low-grade vulvo-vaginitis with a grayish-yellow discharge. The patient was given the usual hygienic instructions and was treated by local applications of argyrol (mild silver protein). Two weeks later she developed a slight rise of temperature and complained of a burning sensation just below and to the inner side of the left breast.

Examination showed an area of erythema, about the size of a dollar. The following day she stated that the area pained her greatly during the night, keeping her awake. Evidence of suppuration was noted and the area was incised, with the evacuation of about a dram and a half of grayish-white pus. Examination of the slide made directly from the abscess contents showed numerous gonococci. Cultures were later obtained in a pure state. I treated the abscess by irrigations of various antiseptic solutions (without much success) over a period of two weeks. The edges of the wound became surrounded by very unhealthy looking granulations. Carrel-Dakin solution was then tried and the pus cleared up in four days, the wound closing in ten.

Case 2:—Y. K.; white; age five years; born in the United States.

This child had a marked case of vulvo-vaginitis, without any apparent urethral involvement. Smears revealed gonococci in abundance. The case showed marked resistance to treatment and about a month after reporting developed arthritis of the left wrist and knee, with considerable general adenopathy.

One week after the appearance of the arthritic manifestations, five light-red, maculo-papular spots appeared on the inner side of each thigh, in close proximity to the labia. Each spot was about an eighth of an inch in diameter. Within the next forty-eight hours these spots had gone through the stage of vesiculation and become pustular. Each of these pustules contained gonococci, both by direct staining of the pus and by culture. These pustules were quite superficial and seemed covered only by epidermis. The epidermal covering of all was removed and the skin found very raw, but not ulcerated. The areas were treated by the direct application of ten-percent argyrol, clearing up in ten days. The vulvo-vaginitis responded very slowly.

Conclusions

In the first patient it is more than likely that we had to do with a local skin infection by the gonococcus. Intermammary coitus is common and had occurred in this instance at least several times, with I believe, a local infection resulting.

The character of the lesions in the second patient suggest a metastatic infection, even though they are not far removed from the source of infection.

The literature on the cutaneous complications of gonorrhea, although not extensive, is most interesting. The appended list covers practically all of the material available, in English, to date.

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PHYSICAL THERAPY AND RADIOLOGY

A Chair of Mechano-Therapy

EVERY medical school or college should establish a chair or department of mechano-therapy. This department should teach the scientific use and application of superficial and deep massage and the proper manipulation of muscles, ligaments, bones and joints in appropriate cases, with the clinical indications for such treatment.

It has long been recognized that mechanical measures of this nature are of inestimable value in certain cases in which internal, hypodermic or intravenous medication is useless. Unfortunately, in most medical institutions, this valuable adjuvant to treatment has been neglected or totally ignored. The deplorable result has been that this class of cases has largely fallen into the hands of charlatans or various unscientific cults, which have flooded the country and deluged the literature with grotesque and ridiculous isms and pathies.

The rheumatic and gouty diatheses are responsible for a very large percentage of these chronic sufferers; while neglected or improperly treated fractures, dislocations and inflammatory affections of muscles, ligaments, nerves and joints account for the remainder. The deposits of salts in the affected parts have resulted from the chronic congestion and sluggish circulation induced by the primary pathologic condition; and the longer this perverted circulatory disturbance is allowed to persist, the more serious do the local manifestations become and the more difficult is the condition to correct.

Swedish massage is practically the only scientific manipulative procedure with which the legitimate profession is acquainted and in which it has received but a modicum of instruction. The average practitioner of medicine knows almost nothing of this method. Consequently, he neglects these cases or falls back upon antiphlogistic and counter-irritant applications and rubbings, usually left to the patient himself, or hopelessly surrenders the patients to the questionable mercy of the unscientific cults.

If there is anything of value in the teachings of these men, in the passive movement of partially ankylosed joints or of inflammatory splinting of muscles and ligaments, or in the stretching of nerves bound down by inflammatory deposits, or in the twisting and bending of feet, then the medical profession should be given the opportunity of knowing these facts and of rationally applying them to the appropriate cases.

Incidentally, the establishing of such chairs or departments would take the wind out of the sails of the absurd systems of treatment which have been foisted upon a public which is not capable of recognizing the absurdity or folly of the merits claimed by the followers of these various theories.

It is mortifying, to say the least, to see published in the newspapers, reports of cases which have fallen into the hands of osteopaths, naprapaths or chiropractors, after the legitimate medical profession has failed, and which have been notably improved or even cured by these often unlearned men. The fault lies mainly, if not altogether, in the neglected teaching of doctors in these therapeutic meas-

ures by the recognized medical schools. If their graduates knew how to treat such cases mechanically, it stands to reason that they would achieve as great success as their unlearned competitors, or even better because of their superior medical knowledge, and thereby materially increase their revenue. The stigma of ignorance would also be removed from the medical profession—a really serious matter, which has done much to lower the value and standing of the medical profession in the eyes of the public.

The work of the chiropodists, who, we believe, should be members of the legitimate medical profession, is largely in the nature of massage. This worthy group of unrecognized medical men might very profitably add to their knowledge the various methods of massage and manipulation and become thereby a very valuable specialty of the medical profession. It is, at least, a suggestion worth considering.

W. A. Newman Dorland, M.D., F.A.C.S.
Chicago, Ill.

The Place of Electrocoagulation in Laryngology

By James E. Tytler, M.D., New York City

SINCE the publication of my recent paper dealing with the electro-coagulation of tonsils,[1] I have received numerous inquiries relative to my technic and the preparation of the patient. The nature of some of the questions asked also indicates that there is considerable confusion regarding the mode of anesthetization employed in electro-coagulation of tonsils.

Before going further I deem it advisable to remind the reader that, while electro-coagulation plays a very important rôle in the armamentarium of every laryngologist, in my opinion it in no way supplants the surgical removal, but rather supplements it in those cases which are poor operative risks; and it has proved valuable where loss of time is an important factor.

The use of this agency for the removal of tonsils and adenoids in children is, in my opinion, absolutely unwarranted. The surgical method, in the hands of a skilled operator, is so absolutely safe, and the danger of the anesthetic, when administered by a skilled anesthetist, so slight, that there is no justification for this longer method.

There are definite indications for electro-coagulation, such as in cases suffering from cardiac involvement, for the aged, and for the patient who presents a history of a hemorrhagic diathesis. I might also add, that I have successfully used electro-coagulation in many cases where the tonsils are small but questionable, and the symptoms, although troublesome, are not of sufficient severity to justify the recommendation of surgical removal.

Bearing in mind that the tonsils should have atrophied and disappeared by the early twenties, tonsils that remain after that are not only of no use, but frequently are a source of infection, even when no actual pus can be demonstrated as being present; and it is for the removal of these small, partially atrophied tonsils that have not entirely disappeared, that I regard electro-coagulation as being of greatest use.

I have treated many such cases showing the results of mild focal infection, evidenced by various symptoms elsewhere in the body, which have been cleared up by a few treatments of electro-coagulation of tonsils which were not badly infected or enlarged, but merely questionable. The results obtained in these removals are truly remarkable.

Anesthesia

Regarding anesthesia for electro-coagulation, injections of any anesthetic are not only unnecessary, but are definitely contra-indicated, since the presence of any fluid within the tonsillar area tends to retard the dehydrating properties of diathermy; and, according to Mayer,[2] the injection of local anesthetics frequently proves fatal to those patients suffering from cardiac involvement. Since a large number of the cases receiving this treatment come under this heading, the infiltration type of anesthesia should be avoided.

Since electro-coagulation requires a number of applications during the treatment, it is important that the anesthetic used be of low toxicity, yet sufficiently powerful to produce adequate anesthesia, especially in cases where cardiac conditions are present.

The anesthetic that I have found most satisfactory for use in electro-coagulation is Phedrocaine, (as was also reported by Haiman[3]), combining as it does, ease of administration, safety and profound surface anesthesia. Herriman[4] reports that the anesthetic properties of Phedrocaine compare favorably with those of cocaine and that there seems to be no effect on circulation or respiration; nor have I noticed any idiosyncrasies against Phedrocaine. Straatsma[5] states that the occasional vomiting associated with the use of cocaine was entirely absent in those cases in which Phedrocaine was employed. This, to me, indicates a very desirable advantage in connection with electro-coagulation, where the patient is so prone to gag and vomit.

Preparation of the Patient

Very little preparation is necessary. A cleansing spray of some suitable antiseptic applied to the tonsils is usually all that I use; anything further is not only unnecessary, but often tends to create undue mental hazard. In my opinion, infection and abscess formation in the tonsil is impossible where the removal is by electro-coagulation. In the many hundreds of cases treated by me in private practice and under my observation in the New York Ophthalmic Hospital, only one case of such infection occurred, and that was undoubtedly due to local infection deep in the tonsil itself, as the patient had had an attack of peritonsillar abscess some time previously. In that case treatments were continued and the tonsil completely removed.

The patient, while waiting for treatment, is given 2 Phedrocaine tablets and instructed to allow them to completely dissolve in the mouth, this usually taking about 5 to 10 minutes. This should provide adequate anesthesia; however, where more profound anesthesia is required, it may be obtained by spraying, or applying topically, Phedrocaine Oil to the inner surfaces of the anterior and posterior pillars and to the tonsil to be treated. The patient is now ready, and should be cautioned not to hold his breath, but to keep breathing during the contact.

Technic

The success obtained with this method of tonsil removal is largely dependent on instrumentation. My best results have been obtained by using a modified bi-polar (or, correctly, bi-active) electrode, the points being about ¼ inch apart, and curved to almost a right angle. With this electrode the tonsil can be engaged and drawn away from the pillars and pharyngeal wall, towards the middle of the throat, before turning on the current, thus lessening the danger of the active points of the electrode coming in contact with the pillars. The needles should be deeply imbedded in the tissue, so as to afford a good purchase; then, with a rotating motion, the tonsil can be drawn away from the pillars and the electric current turned on for 3 or 4 seconds.

Treatments are given about five days apart, and the number of treatments I find necessary varies with the size of the tonsils to be removed, from two treatments, for a small tonsil, to eight or ten for a tonsil of large size.

Post-operative pain can be controlled by dissolving a Phedrocaine tablet in the mouth at frequent intervals, these tablets being equally efficacious in allaying pain subsequent to the surgical removal of tonsils. I have also found them to be of great value as a palliative in acute tonsillitis and in tuberculous laryngitis, where they appear to control the cough reflex.

In conclusion I am satisfied that electro-coagulation very definitely has an important place in the armamentarium of every laryngologist, for the removal of small tonsils in adults; but I personally believe that, when the tonsils are of some size, the surgical technic, in the hands of a skilled operator, is the method of choice, except in those who would be poor operative risks.

The use of infiltration anesthesia is contraindicated in electro-coagulation. It has been my experience that Phedrocaine is the best of the surface anesthetics for this type of work.

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NOTES AND ABSTRACTS

Radiologic Specialization*

ANIMATED by high ideals, the American Board of Radiology was recently formed, but whether it is going to rise to the heights it aspires to appears somewhat questionable at the moment. Apparently it has struck a "snag" in regard to the subject of radium therapy, inasmuch as a decision has been made to abide by the resolutions adopted last June (1934) by the American Radium Society and the American College of Radiology; that is, to refuse certification in any branch of radiology to any physician who rents his radium to non-radiologists; also refusing to certify non-radiologic specialists as radium therapists. In other words, it would appear that one of the aims of the newly created American Board of Radiology is to place the entire control of all radium therapy in the hands of those radiologists who hold certificates from that Board. Carrying this idea out to its final conclusions it means that all gynecologists, urologists, dermatologists, surgeons, general practitioners, etc., who are occasional users of radium, must immediately cease this practice and turn over all patients in need

*Radiol. Rev., Jan., 1935.

of radium treatment to those radiologists who hold a certificate from the American Board of Radiology.

If there ever was a more bold attempt to completely dominate a medical situation, we have not heard of it in recent years. Apparently, the American Board members do not fully appreciate that, in many instances, the non-radiologic specialist is much better qualified to diagnose the condition and administer the radium treatment than is the average radiologist; we refer especially to certain gynecologic, urologic, and nose and throat conditions. They seem to forget that many of the men who have done so much to popularize and establish radium therapy were not primarily radium therapists, and we especially refer to a long list of eminent gynecologists, dermatologists and surgeons. Only recently the well-known gynecologic surgeon, H. S. Crossen, professor of clinical gynecology at Washington University School of Medicine, stated:

"The requirements for the use of radium follow the same general principles as for the use of the knife or any other potent remedy —namely, adequate knowledge of the anatomy, physiology and pathology of the structures involved and the effects of the remedy upon them.

"There is a clear path for those who wish to use radium conscientiously and with safety and full benefit to their patients. And no one is better fitted to follow that path than the surgeon, grounded in the fundamental knowledge of the structures with which he deals, and experienced in the skillful touch and sound judgment required in serious surgical work."

The field of radium therapy runs the entire gamut of medicine, and the number of patients in need of radium treatment is great and so widely distributed that it is preposterous to expect that all radium treatments be given by only a small group of certified radiologists.

This controversy cannot fail to convince the practicing physician that radium must be a potent therapeutic agent with a brilliant future, otherwise, why the efforts to entirely control that field?

HAROLD SWANBERG, M.D.

Quincy, Ill.

Cholecystography*

CHOLECYSTOGRAPHY is a sure and precise method of exploration.

The oral administration of tetraiodophenolphthalein, according to the technic of Kirklin, gives results completely comparable with those obtained by the intravenous injection of the dye, and thus offers a handy method and freedom from accidents.

A good visualization of the gall-bladder does not necessarily mean that it is in a healthy condition.

Gastro-duodenal ulcers are not of great importance in the filling of the gall-bladder.

Benign or malignant tumors are more common than we have been led to believe, and these present characteristic roentgenologic signs.

Slow emptying of the gall-bladder is not always a symptom of disease.

Roentgenologic interpretation of cholecystograms is now so minute and reliable, that the clinical value of this procedure may now be regarded as of the highest order.

DR. RAMON CARRANCA Y TRUJILLO.

Mexico, D. F., Mex.

*Revista de Radiologia Y Fisioterapia, Nov.-Dec., 1934.

BOOKS

Actinotherapy

ACTINOTHERAPY TECHNIQUE. An Outline of Indications and Methods for the Use of Modern Light Therapy. *With Foreword by Sir Henry Gauvain, M.D., M.Chir. (Camb.), F.R.C.S. (Eng.). Newark, N. J.: Alpine Press, Inc. 1933. Price, $1.00.*

This little book is issued by the Hanovia Company, apparently to promote the sale of their apparatus. The name of the author or compiler is not given, but the writer of the "Foreword" (occupying one page) appears prominently on the title page.

The information in the chapters on Physical Data and Dosage appears to be accurate and is suitable for quick reference; but since the book recommends actinotherapy for a surprisingly wide variety of diseases in which its value is by no means fully established—from alopecia and angina pectoris, through migraine, poliomyelitis and psoriasis, to xanthoma—it can hardly be looked upon as a reliable compendium of scientific therapeutic information.

The volume is attractively printed and bound, but in view of its presumptive advertising value to its publishers, the price seems rather high.

D. H. A.

NEWS

American Congress of Physical Therapy

THE annual meeting of the American Congress of Physical Therapy will be held in the auditorium of the Service Memorial Institute, Madison, Wis., March 12, 1935. The program will fill the entire day and evening. For full particulars, write to Marion G. Smith, Executive Secty., 30 No. Michigan Ave., Chicago.

A LIVING FOR THE DOCTOR

(The BUSINESS of Medicine)

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History and Health Insurance

By John R. Neal, M.D., Springfield, Ill.

DURING the eleventh century a wave of religious fervor swept over western Europe, manifesting itself in what are known as Crusades. Conceived in the minds of religious and political leaders of high purpose, who failed to weigh judiciously the difficulties and costs involved, the idea of pilgrimages to the Holy Land caught the popular imagination. Enthusiasm was whipped to fever heat and fanned into burning zeal by those who wanted to save the world for Christianity. The sad experiences of that gigantic movement are a matter of common knowledge. Life and money were lost on a prodigal scale, the like of which has never before or since been recorded. One of the Crusades carried into eternity a multitude of children who were recruited into an army of religious zealots bent upon a pilgrimage to Jerusalem.

Even if the Crusades had succeeded substantially in the furtherance of Christianity, the cost was inordinately heavy and out of all proportion to any benefits that might have been obtainable by that process. Much ground has been gained toward the practical application of Christian principles, by sounder methods than the Crusades. It is significant to observe, furthermore, that, once the Crusades gained momentum, three hundred years were required to check the movement.

Now there is on foot in the United States a movement which would save the nation through a medical scheme—health insurance. The idea has become a fetish in the minds of certain social and political leaders, who have not weighed the costs and the difficulties against the possible advantages or benefits which might be forthcoming. There is, however, a great deal of practical experience which will serve as a basis for sound thought on this subject.

The United States Army may be taken as a group which has had available to its members a medical service far superior to that which might be expected from any health insurance scheme for the general population or any considerable part of it. On the other hand, the United States Public Health Service made a detailed study of the health experience for one year of 9,000 families, embracing about 39,000 individuals located in all parts of the United States, who depended upon calling a doctor for medical service. A comparison of health conditions among these two groups should show a very decided difference in favor of the army in order to make valid the claim that health insurance will result in significant benefits to the general population.

A record is kept in the army of every officer and every soldier who reports for sick call. In the study of the 9,000 families, which included people of all income brackets, with one-half falling in the $1,200 to $2,000 per year income class, a nurse visited each family regularly for one year and made a record of every illness, including colds and accidents. The army includes only adult males, who had to pass a physical examination prior to acceptance. The families include both sexes of all ages, and 40 percent were children under fifteen, who suffer more frequently than do adults from communicable diseases of all kinds.

During 1933, there were 578 cases of illness (including accidents) per 1,000 officers and men in the army, according to the report of the Surgeon-General of the Army. Among the 9,000 families there were 516 cases of illness (including accidents) per 1,000 people per year, which caused the loss of one or more days from school, work or other occupation. For all illnesses, including inconsequential colds, the rate among the families was 850 per 1,000. In the army a physician saw every case recorded. Among the families a physician saw 79 percent of all cases, and 85 percent of all cases exclusive of colds.

In the army the officers and troops lost an average of 10.7 days per year because of illness or accident. This figure is almost as high as the lost-time average among wage earners in the general population.

These observations are clear and valid evidence that, under the present system of medical care, the general population enjoys health conditions fully as favorable, all things considered, as the army personnel. They show, further, that medical service is available and is generally used by people who

need it (79 percent of all ills of whatever nature, among the 9,000 families, were seen by physicians). Certainly no reasonable person would believe that a system of health insurance would provide a medical service equal to that provided for the army.

There is, furthermore, the factor of military discipline in the army. Prophylaxis and other preventive and control measures, such as inoculation against various diseases, can be and are imposed upon the personnel. Officers and troops are required to take advantage of medical facilities. Manifestly no such disciplinary means could be employed in respect to people who would come under a health insurance scheme.

That neither preventive nor curative medicine can be thrust upon people is shown clearly by two studies, one in reference to immunization against diphtheria and the other in respect to rheumatism. The Metropolitan Life Insurance Company took a census of 6,245 children in the age group of six months to fifteen years, to find out how many were protected against diphtheria and the reasons, when this was lacking. Of the 4,749 unprotected children, the parents of one-half declared that they had simply neglected the matter, while another one-fifth (20.5 percent) were opposed to the procedure and deliberately refused to have the children inoculated. Only 6.7 percent of the parents gave economic reasons for not having the children protected. These children lived in communities where diphtheria prevention campaigns had been well advertised.

With reference to rheumatism, a house-to-house canvass, by the State Department of Public Health, of one percent of the people in Massachusetts, revealed that two-thirds of the victims failed to take advantage of medical care. This was true in spite of the fact that many of the rheumatic patients were well able financially to obtain medical care.

Is it seriously believed that a health insurance scheme would so change the mental attitude of these people that they would forthwith demand immunization for their children and medical treatment for their rheumatic ills? No student of human nature would so conclude.

With respect to cost, it appears that the army spends about $4,254,000 annually, for salaries only, in providing medical service for about 137,000 officers and men—an average of $30 annually per person served. If hospitals, surgical and other equipment, medicines and supplies are added, the cost would probably be about double. Anything that approaches adequacy under a health insurance scheme could not cost less. A cost rate of such magnitude would be a severe burden upon an already heavily taxed people.

This is not theoretical reasoning. It is merely facing the facts honestly and in the light of actuality. The army and the 9,000 families were used so as to illustrate what has happened under American conditions. Comparisons could be made between prevailing health conditions in this country and those of several European nations where health insurance schemes have been operating for years. All general mortality and sickness rates are more favorable in the United States.

The agitation for health insurance has appealed to the popular imagination. Calm reasoning shows clearly that it would be expensive and non-productive of the benefits held out. The movement, however, has attracted to its banner many able politicians. All history makes this understandable. Politicians invariably promote issues which can be held up as favoring the common man. This is their business. In health insurance they find a ready-made issue similar, in many of its psychologic features, to the Crusades.

Physicians everywhere need to recognize the situation. The movement has already gained no little headway. It will not die with the end of the current legislative season. Thus the medical profession must gird itself for a permanent program if it is to remain a free and unhampered calling.

Every doctor who believes in maintaining confidential relations between himself and his patients; every doctor who appreciates the benefits of individual initiative, needs to be constantly on the alert in respect to this problem. He should make it his business to present the facts to business acquaintances, to political office holders, to friends of influence, and he should lose no opportunity to speak before civic clubs on this subject. Medical societies could do no better than to arrange public meetings from time to time, with a program of able speakers to discuss the subject of political health insurance schemes.

609 So. Walnut St.

THE GREAT DOCTOR

The great doctor must know almost as much about the social order as the sociologist; almost as much about the mind as the psychologist; as much about the subtle art of counselling as the priest. He must refuse to commercialize his profession and decline to tear his specialism out of the living texture of the medical fabric. He must be able to distinguish between Hippocratic ethics and hypocritic etiquette.—GLENN FRANK.

NOTES AND ABSTRACTS

How Is It?

THAT when a doctor sends a bill to a fellow for $50 for two weeks' treatment, pulling him through a critical case of pleuro-pneumonia, he hollers for the police—and when the lawyer sends him a bill for the same amount for one hour's appearance in court he thinks he's getting off cheap?

That when a plumber, butcher, baker or milkman jumps into a creek or salt meadow to save an old soak from drowning himself, the papers hail him as a hero and Congress presents him with a life-saving medal—and when the doctor, through the use of brain and trained skill of a highly specialized order, working night and day, saves the life of a useful citizen, it is considered just a duty done and no hero medal is awarded, or even mention made of the incident?

That when the tired doctor, seeking needed relaxation like other folks, steals away for a few hours from his office to go to a show, or for a week-end in the country, he is grilled and toasted for neglecting his patients—and when a preacher, a lawyer, an engineer or any other professional man does the same thing, not an unfriendly word is said or unfriendly criticism made of the circumstance?

That when a baby is named by an appreciative mother after the family physician who brought it into the world, folks snicker, shrug their shoulders suspiciously and whisper, "I told you so"—and when it is named after a politician, soldier, captain of industry or a banker, it is accepted as a matter of course and no thought of suspicion is ever excited over the incident?

That when the doctor squeezes the hand of a pretty woman patient, or pinches her on the cheek, it is food for hostile gossip—and when the dominie does likewise it is just a token of spiritual solicitude for her health?

That when a fellow owes money to his doctor, he assumes an injured feeling when pressed to pay—and when pressed by his banker to pay is obsequiously deferential and polite?

That when no merchant on earth will give a fellow credit for a nickel's worth of merchandise, or call at his home on anything except a cash basis—the doctor will trust him and his family for hundreds of dollars' worth of service and never desert him while he is in need of help?

That when medical men ask an appropriation to protect a community from disease and death, legislators turn it down as a needless dissipation of public funds for "foolish medical experiments"—and when a politician interested in promoting a new type of street sweeper, water cooler or office rugs asks a similar appropriation, he gets it P. D. Q.?

How is it?

F. R. BRAUNE, M.D.

Chicago, Ill.

[We shall be glad to have our readers comment upon these obvious injustices and suggest measures for their correction. Perhaps merely bringing them to the attention of the public (as Dr. Braune does) may be a help. What do *you* think?—ED.]

Social Service Workers

LISTEN to this through your stethoscope: In 1920 there were *nine* (9) social service workers who reported an income tax; in 1933 there were *66,000* social service workers who reported an income tax. . . . They say they have the "Docs" well in hand. This ought to give you ideas on the type of education your children should receive in order to keep them from financial instability. . . . A medically-minded social service worker is as rare as a bicuspid in one of the avian family.—*The Private Physician*, Jan., 1935.

Explanation of the Medical Emergency Relief Program*

AS part of the relief given the unemployed, the Federal Government will, within certain limits, pay for medical attention given by their family physicians. The program being an emergency one, medical care is not ordinarily authorized for conditions that do not cause acute suffering, interfere with earning capacity, endanger life, or threaten some permanent new handicap that is preventable when medical care is sought.

A physician who accepts a patient under this arrangement agrees to furnish the same type of service to an indigent person as would be rendered to a private patient, such service to be a minimum consistent with good professional judgment. This has been interpreted as meaning a minimum service to meet the needs of the specific case.

In acute illness, however, medical care is limited to not more than two weeks, during which period not more than ten visits may be made. In chronic diseases, on the other hand, medical care is limited, in general, to not more than one visit a week for a period not exceeding two months. When, moreover, a physician accepts an obstetric case he agrees

**Weekly Roster & Med. Digest.*, Jan. 9, 1935.

to make six properly spaced prenatal visits and three postnatal visits.

The Relief Administration, in turn, agrees to pay two dollars for a house visit, one dollar for an office visit and twenty dollars for an obstetric case. According to Federal Regulations, all fees are established on the basis of an appreciable reduction from the prevailing minimum charges for similar services in the State and local communities, with due recognition of the certainty, simplicity and promptness of payment that authorization from the local relief administration insures. The common aim is the provision of good medical service at a low cost, to the mutual benefit of the indigent patient, the physician and the taxpayer.

MYER SOLIS-COHEN, M.D.
Philadelphia, Pa.

The Bureaucratic Snowball

THE Reconstruction Finance Corporation was devised as a temporary expedient. Loans were to be made to organizations which were inherently sound but which were in difficulties because of their inability to obtain credit in the midst of financial panic.

Now the corporation is asking authorization to extend loans to solvent and to new mortgage companies; it is requesting an additional two years of life; and it wants the maximum term of its loans extended from five years to ten.

Here is another evidence of the age-old truth that bureaucracies never surrender. A temporary organization, improvised to meet an emergency situation, is no sooner born than it begins to reach out for more appropriations, more power and a longer life. The occasion which called it into being may long have been forgotten, but it goes on and on. The longer it lives the deeper its roots strike. The money it distributes and the patronage it provides give it the political influence to extend its operations further.

There is only one cure. It is the ax! The politician who temporizes with a bureaucracy is licked before he starts.—Editorial in *Chicago Tribune*, Jan. 29, 1935.

Publicity of Income Taxes

DO you want the inquisitorial and un-American income publicity law repealed? It can be done if even *twenty-five percent* of those citizens who resent it will express a demand for its repeal.

Right now, write to your senators and congressmen at Washington (or, at least, to one of each), telling them, in no uncertain terms, how you feel about it. Tell your friends to do the same thing.

Write to the editor of at least one newspaper in your town, telling him the same thing, and get several of your friends to do likewise.

When you make out your Income Tax report, write across the face of your pink slip, "I protest against this outrage to the right of privacy." If you can afford the $5.00 penalty for not filling out this slip, send it in with only the message on it; but put on the protest *anyway*.

Write to Sentinels of the Republic, 1830 Land Title Bldg., Philadelphia, Pa., for information about the work they are doing to save our American traditions.

Health Insurance

THE unemployed, still numbering close to ten millions, would be unaffected by compulsory health insurance. The small wage-earner would, 90 percent of the time, have to expend more, in direct contributions and indirect taxation, than at present. For this he would not receive anything better in the way of medical care than he gets now.

The profession is fully alive to the need for a redistribution of medical services so that all the people may receive all the benefits of modern medicine, regardless of economic status. In a number of cities, with municipal cooperation, it has instituted programs that have given far more satisfaction to all concerned than sickness insurance. Like the sales levy, compulsory health insurance is an attempt to broaden the basis of taxation by making the lower classes pay more.—MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

DEBTS AND EXCESSIVE TAXES

The germ of the ill which affects this nation is excessive taxes. That is beyond dispute and we do not know that any one has even so much as undertaken to successfully refute it, although there are many, of course, who seek to present other ideas, in order to distract our attention. Not only must the cost of conducting government be reduced to something like a fair figure, but the indebtedness piled upon the people because of money borrowed by counties, cities, states and the federal government, must be reduced. If we are honest we cannot shift our responsibility by seeking to avoid the full payment of our debts. The man who goes into bankruptcy to punish his creditors and conceals a large part of his assets, if discovered, is severely punished. Then, should any government, whether a school district, county, city, state or federal, do it?—COMMITTEE ON AMERICAN EDUCATION.

THE SEMINAR

"A MONTHLY POSTGRADUATE COURSE"

(NOTE: Our readers are cordially invited to submit fully worked up problems to the Seminar and to take part in the discussion of any or all problems submitted.

Discussions should reach this office not later than the 5th of the month following the appearance of the problem.

Address all communications intended for this department to The Seminar, care CLINICAL MEDICINE AND SURGERY, Waukegan, Ill.)

Problem No. 1 (Surgical?)

Presented by Dr. Charles J. Drueck, Chicago
(See CLIN. MED. & SURG., Jan., 1935, p. 44)

RECAPITULATION: Mrs. N., 30 years old and the mother of three children, has always been well and had normal menses.

Six months ago she noticed discomfort in the pelvis when sitting—as if the rectum were full, but going to stool did not relieve it. This became worse, until she felt as if she were sitting on an uneven surface and there was a constant, dragging ache in the pelvis.

Examination was negative, except for the presence of a mass the size of a small fist in the left pelvis, movable and not in the rectum nor attached to the uterus.

Requirement: Probable diagnosis and suggested treatment.

Discussion by Dr. C. H. Kennedy, Fort Smith, Ark.

The patient's age would probably exclude malignant disease; and the absence of pathosis in the rectum and sigmoid would exclude enterolith or fecalith.

Regular menstruation and a mass disassociated from the uterus, would exclude uterine fibroid or trouble in the left tube.

Being "well nourished" might mean plumpness or somewhat fat and might suggest the possibility of endocrine disturbance.

The appearance of the mass and its apparently rapid development without fever, would suggest ovarian trouble; and firmness as opposed to fluctuation, might exclude cystic ovary.

Diagnosis: Ovarian hematoma. *Treatment:* Immediate operation.

Discussion By Dr. G. C. Croston, Sapulpa, Okla.

This is the kind of case one should consider the most interesting, because it is almost impossible to make an exact pathologic diagnosis pre-operatively. One has to take into consideration the percentages of probabilities and possibilities.

The first statement Dr. Drueck makes, that "she is well nourished and cheerful," allows one to presume that the patient's basal metabolic rate is normal or about normal and that her nervous system is free from deleterious toxic effects.

"Temperature and pulse normal." One concludes that she is free from any great amount of generalized systemic toxemia. The "chest and abdomen negative" eliminates any number of infective conditions in the pelvis, that would, by their reflex disturbance upon the sympathetic or para-sympathetics, interfere with the normal integrity of function in the abdomen and chest.

"Digital examination of the pelvis locates a mass which is not within (the lumen of) the rectum," and is "painful to manipulate," "firm," "the size of a fist," "not tender."

A few other descriptive terms might help one before deciding on an affirmation or negation, as to its probability, such as, for instance:

1.—Any putty-like indentation?

2.—Actual size, shape, form and consistency.

3.—Degree of movability in different directions—"12, 3, 6, 9 o'clock."

4.—More definite relationship to rectum, sigmoid, colon, uterus, tubes and ovaries.

One should consider, from a differential standpoint, and dispose of by a process of elimination, the following neoplastic or tumefactive conditions.

1.—A draining peri-rectal abscess.

2.—Foreign body in the wall of the rectum or sigmoid.

3.—Carcinoma.

4.—Sarcoma.

5.—Diverticulum of the rectum, or a sigmoid full of hardened feces.

6.—Diverticulum of the urinary bladder, full of stones.

7.—Prolapsed left kidney.

8.—Ovarian cyst.

9.—Dermoid cyst.

10.—Pedunculated uterine fibroid.

In the absence of further diagnostic data,

such as x-ray findings of the rectum, colon, appendix; or in the urinary bladder following urography; or a complete urinalysis, blood count, etc., one would be inclined to hazard a guess as to the diagnosis, in order of probability: (1) Ptosed or prolapsed left kidney; (2) dermoid cyst; (3) pedunculated uterine fibroid.

Treatment: For prolapsed kidney, let it alone or forget about it or assume a position of watchful expectancy. For dermoid or fibroid, advise removal.

Discussion by Dr. E. C. Junger, Soldier, Ia.

There need be no question mark after the "Surgical," in the title of Problem No. 1.

The fact that the patient has had children and no menstrual irregularities would rule out uterine fibroids and ectopic gestation. That leaves nothing for serious consideration except ovarian or dermoid cyst.

The treatment is surgical removal of the tumor.

Solution by Dr. Drueck

Mrs. N. submitted to an operation, and a tumor of the left ovary, the size of a lemon, was found. It was not adherent, but had a long pedicle and lay on the pelvic floor. The pathologist pronounced it a dermoid cyst of the ovary. She is now very comfortable and has no pain when walking or sitting.

I theorize that the tumor, being free in the pelvis, dropped down on the pelvic floor, sometimes behind the uterus, where its weight and position caused tenesmus, much as fecal impaction of the rectum would do.

Until recently I thought that an ovarian tumor causing ano-rectal symptoms was a unique finding; but I recently discovered a report by Montague (*J.A.M.A.*, Nov. 29, 1924, p. 1748) of a case of a woman whose only complaint was ano-vulvar pruritus. Examination revealed no local or general cause, except a mass in the right pelvis. Operation revealed two large ovarian cysts, whose removal was followed by complete relief of the pruritus.

Problem No. 3 (Surgical)

Presented by Dr. Gustavus M. Blech, Chicago

A laborer, Italian, aged 46, was first seen by a general practitioner for a very painful process of his left wrist. This physician diagnosed an infective arthritis of unknown cause (the patient denied any trauma) and ordered hot magnesium sulphate poultices, which treatment, though conscientiously carried out in the patient's home, not only failed to alleviate the pain, but, if anything, is said to have increased it. Three days after the first visit and four days after the onset of the process, the attending physician, fearing deep-seated infection of the joint, advised exposure of the infected region by deep incision, under general anesthesia. This the patient refused and demanded consultation.

The consultant saw this patient the following day—the fifth after the onset. The history then taken showed that the patient had some disease in childhood (probably scarlet fever), but, aside from an attack of diarrhea during the late War, he never was ill. He had spent some time in Italian trenches during inclement weather but was not injured or wounded. He married soon after the armistice. His wife lived with him for five years, when she died, probably from pneumonia. There were no children.

General *physical examination* was essentially negative, with reference to constitutional disease or local infection. He had a slightly congested throat, which may be attributable to excessive smoking. The tonsils and teeth appeared to be normal. His pulse was 100; respiration, 34; temperature, 100.6° F.; blood pressure, 130/75; Wassermann reaction of the blood was reported negative the day following the consultation. Other blood examination was not made, for external reasons, nor, be it added, was there any especial indication for it.

Physical examination of the wrist showed an exquisitely tender, swollen joint, with extensive edema. Striking was the fact that there was no other evidence of inflammation. The skin, instead of being reddened, showed, if anything, a shade of pallor. Fluctuation was not detectable, even after the patient was induced to allow deep palpation, which gave the examiner a feel of tough tissue in spite of the edema. The turbid urine was examined last, but the filtered specimen showed neither albumin nor sugar. At this stage, several neighboring physicians saw the patient and made various diagnoses. The consultant, however, came to a diagnosis which was soon confirmed.

Requirements: (1) Probable diagnosis; (2) method or methods, if any, to confirm the diagnosis; (3) operative or other indicated management.

ALTRUISM

The altruist should not be regarded as a martyr, for he is not relinquishing his right to happiness. He has merely learned an adult means of gaining happiness, in place of the egocentric ways practiced by a child.—Prof. John J. B. Morgan, *in "Keeping a Sound Mind."*

CLINICAL NOTES and ABSTRACTS

Comments on Endocrine Balance

WITH every decade, the increasing importance of the glands of internal secretion, in relation to various organic disturbances, is shown. Each of these glands is of vital import in relation to health. Each must maintain its required activity within its normal range. It must neither be overnor under-active, otherwise a chain of symptoms will arise to harass or render invalid its unfortunate host. The extent of disturbances due to one improperly functioning gland does not, unfortunately, end in organic dysfunctions limited to that specific gland. Because of intimate inter-relations between these glands with each other the upset may become exceedingly complicated, one gland upsetting a whole series of other glands.

Fortunately the endocrinologists are, not only unfolding the mysteries of the specific functions of these very vital organic units, but are, more and more, analyzing their inter-relationships to more exact degrees. Practitioners in any field must indeed be asleep not to pay cognizance to the developments in endocrinology, for no field of medicine or surgery is untouched by factors of great importance in the matter of endocrine balance.

Not many decades ago, we allowed, in our ignorance, many patients to die because we did not know what caused low blood pressure. In these modern days we bring back a normal pressure with adrenal and other gland products. Recently a study has indicated that there may be a corrective power for undescended testicle in pituitary extract. In a late journal, evidence is submitted to show a relationship between urinary stone formation and hyperparathyroidism.

One phase of glandular insufficiency has commanded a great deal of my attention and thought, that of faulty ovarian development. Purely from the standpoint of physiology, when the ovaries arrive at a functioning stage they should be used. In other words, marriage should occur at a far earlier age than modern economic situations usually permit. There is no artificial stimulation of any organ equal in developmental effect to that of proper functional use of that organ. Hence it is most often seen that women who marry fairly early, say at eighteen to twenty, as a result of the resultant normal function, undergo, very often, rapid and great changes in development, physical as well as mental. I believe that ovaries in no way stimulated until late, say in the thirties, very often have become so arrested in growth as to have become incapable of ever reaching a final normal degree of development. Not only, in this interim, have the ovaries become rudimentary, but the entire organic system has often suffered irremedially.

Moreover it appears that the ovaries and other sexual adnexa, as the uterus, when not allowed the privilege of normal functioning, very often assume vicarious activities in the formations of cysts, fibroid tumors and other bizarre growths. This phase of abnormality has been repeatedly observed by me in women belonging to a religious order forbidding their marriage.

I might relate an experience which brought before me the importance of ovarian function (stimulated at a susceptible age), in relation to physical development and in overcoming serious organic disease.

A patient, Miss M., aged 18 years, came to me with suspected tuberculosis of the left kidney. She had been treated at a general hospital for pulmonary tuberculosis, and had shown several positive skin tests. She had alkaline deposits in her bladder, with a left-sided "golf-hole" ureter, and displayed symptoms of left-sided renal tuberculosis. Smears and twenty-four-hour centrifuged specimens of her urine, even guinea pig innoculations, failed to confirm the diagnosis, and, although I felt certain of kidney tuberculous involvement, we were not justified in removing the kidney without absolute proof.

Her bladder responded readily to local treatment and, after a short time, she asked my permission to be married, which she finally did against my advice. After her marriage she continued under my care, and I was astounded at her rapid general physical and mental development and improvement in health along the "honey-moon trail." Having now been under my observation for five years, she is apparently hearty and well, with practically a normal blood-urea and phenol-sulphonephthalein elimination test.

I feel that the stimulation of her ovaries through marriage was far more responsible for her "cure" than anything I could have done for her, and the incident opens up to me an entirely new line of thought and study. Perhaps female frigidity is sometimes caused through too-long continued virginity.

EDWARD S. POMEROY, M.D.
Salt Lake City, Utah.

Nutritional Xerophthalmia*

A FARMER, age 53, came complaining of rapidly failing vision, which had been developing for some time and recurred every winter, improving during the spring and summer months. His winter diet consisted of potatoes, bread, oatmeal, sugar, thoroughly cooked meats and black coffee. In season, he added oranges, radishes and cabbage, and in the spring some eggs. He used no milk, cream or butter.

He entered the hospital in February, 1929, where a diagnosis was made of kerato-iritis, with possible keratomalacia. Laboratory examinations were negative. He was given regular hospital diet and local treatment, as indicated.

In February, 1934, he again came for treatment because he could not see to work, was losing strength and felt unsteady on his feet. His corneas were dry, opaque, lusterless and insensitive, with superficial vessels extending from the limbus to the center. Hypopyon was present in the left eye. Vision was limited to counting fingers at ten inches. The lid margins were swollen and the lashes covered with dried, greenish-yellow discharge.

General treatment consisted of the regular hospital diet, with the addition of extra butter, 12-percent milk, cereal with 20-percent cream, and two ounces of malt syrup, containing 13,500 U.S.P. units of vitamin A per ounce, daily. Local treatment included warm irrigations with 1:6,000 Metaphen solution every three hours; drops of 1-percent atropine solution three times a day; and 1:5,000 mercurial ointment at bedtime. On the third day the symptoms were exacerbated, but responded well to an intravenous injection of typhoid vaccine. Later his teeth were extracted.

Under this treatment, which consisted, essentially, of increasing his intake of vitamin A, the patient recovered completely, but with permanent damage to his eyes, the vision being 20/100. Hemeralopia was not present at any time.

J. A. Thorson, M.D.

Dubuque, Ia.

*J. A. M. A., Nov. 10, 1934.

Easterners at the I. P. G. M. A. Meeting

I HAVE just read, with much interest, the account of the Interstate Postgraduate Medical Association meeting, in the January, 1935, Clinical Medicine and Surgery, especially the statement, on page 26, "The local men did not make such good use of their opportunities as their confreres in the Midlands are in the habit of doing."

The actual registration figures, however, showed that the attendance was greater in Philadelphia than it was in Cleveland, at the 1933 meeting, or in Indianapolis in 1932, and a very large percentage of the registration was from the territory east of the Allegheny Mountains, with several hundred paid registrations from Philadelphia.

Frank L. Devine,
Philadelphia Chamber of Commerce.
Philadelphia, Pa.

[As the I. P. G. M. A. does not publish registration lists like those printed by the A. M. A., it was impossible to check the figures accurately, and the statement in controversy was based upon an impression (which was, perhaps, erroneous), conveyed by certain officials of the Association to the writer.

In order that an apparent error may be corrected and no injustice be done, we are glad to publish Mr. Devine's statement and this word of explanation.—Ed.]

Use of the Pessary in the Puerperium*

ALL post-partum patients should be examined during the third week of the puerperium. Those showing evidence of poor involution, with a large, sagging, boggy uterus, accompanied by backache and bearing down, can be treated and relieved by the use of a properly fitting pessary. A No. 3 or 4, narrow, Smith-Hodge pessary is inserted, allowed to remain for two weeks, and then replaced by a smaller size, which is removed at the end of involution.

My own experience for the past two years in the use of the pessary in this manner has proved most gratifying.

Louis A. Siegel, M.D.

Buffalo, N. Y.

*New York St. J. Med., Feb. 1, 1933.

Motion Picture on Malaria

A MOTION picture film is now available, giving a comprehensive picture of the subject of malaria—the geographic distribution of the disease; the geologic characteristics of a highly malarious area; followed by animated views of the life cycle of the mosquito. The mode of transmission and the clinical signs of malaria are clearly explained, and there are also scenes of antimalarial public health measures, taken in the field by a professional motion picture crew under the supervision of an epidemiologist and a sanitation engineer.

Officers of national, state and county medical societies, hospital staffs, medical colleges and nurses' training schools may obtain this motion picture for presentation to any of

these organizations, without charge or obligation. "Malaria" is available in four reels (running time 35 minutes) in two widths—the amateur standard (16 mm.) and the professional standard (35 mm.). Applications should be made to the Motion Picture Division, Winthrop Chemical Company, Inc., 170 Varick Street, New York, N. Y.

Sodoxylin in Renal Calculus

FOR about fifteen years, I have been treating renal calculus with Sodoxylin, with satisfactory results which, in some cases, have lasted during this entire period.

I treated one patient, whom I never saw, on the basis of a description given by his sister, who was a patient of mine. The man was a cooper, but had been unable to work for three years on account of stones in both kidneys, demonstrated by x-rays. I prescribed Sodoxylin, and at the end of three months he was able to return to work and has continued in good health since then.

Recently I treated three patients who had severe renal colic. After taking Sodoxylin for a few days, all three of them passed calculi. They continued to take the medicine for several weeks, and have had no return of their trouble.

V. VAN WILLIAMS, M.D.

Baltimore, Md.

[Sodoxylin has generally been looked upon as an effective and reliable intestinal tonic and antiseptic; but we have never before heard of its use in urinary lithiasis.

Have any of our readers had similar experiences? Who will attempt to explain this action?—ED.]

The Advertising Pages are part of what you pay for. Use them!

Sodium Formaldehyde Sulphoxylate in Mercury Poisoning*

SODIUM formaldehyde sulphoxylate saved nine of twelve dogs from a fatal oral dose of corrosive mercuric chloride, when administered by mouth and intravenously within an hour and a half after the poison had been taken. The nine surviving animals were protected against kidney damage, as shown by the lack of elevation of the blood nonprotein nitrogen. In the dogs that succumbed following this therapy or following intravenous therapy only, no significant renal lesions were demonstrable histologically.

The sulphoxylate was used in ten human cases of acute poisoning from corrosive mercuric chloride, and recovery occurred without appreciable kidney damage.

*J.A.M.A., Apr. 21, 1934.

In using this drug by mouth it is desirable to have sufficient sulphoxylate retained in the stomach so that some of the unchanged drug will pass down the alimentary canal. If vomiting is severe, the use of morphine hypodermically may be helpful. If little of the drug is retained, the use of high colonic irrigations with a 1:1,000 solution of sulphoxylate is indicated. The other requirement is to give sufficient amounts of the drug intravenously to confer on the blood for several hours the ability to reduce corrosive mercuric chloride. To this end, in the average adult human case, the following procedure is suggested:

Gastric lavage is done through a stomach tube with a 5-percent solution of sulphoxylate, approximately 200 cc. of this solution being left in the stomach. Later it may be given dissolved in iced orange juice. Immediately following this, 10 Gm. dissolved in from 100 to 200 cc. of distilled water† are slowly injected intravenously, from twenty to thirty minutes being permitted for the injection. From four to six hours after the completion of this injection, the intravenous administration of from 5 to 10 Gm. of sulphoxylate may be repeated in severe cases. If it is feasible to test the blood serum against corrosive mercuric chloride, the time that this reaction becomes faintly positive or negative (from three to five hours) may be taken as an indication of the time to give this second intravenous dose of sulphoxylate. If colitis later develops, I employ high colonic irrigations with a 1:1,000 solution of sulphoxylate, once or twice daily.

SANFORD M. ROSENTHAL, M.D.

Washington, D. C.

†Commercial samples of technical sodium formaldehyde sulphoxylate are impure and are not suitable for intravenous injection. A purified product should be used, and the solutions should be freshly prepared. Preparations of the drug suitable for this purpose and sealed in ampules, with the exclusion of oxygen, may be obtained from manufacturers of neoarsphenamine. We are indebted to Merck & Co., New York, the Diarsenol Company, Inc., Buffalo, and the Dermatological Research Company, Philadelphia, for a supply of these ampules.

Priority for Peritoneoscopy

I ENJOYED Dr. Dorland's "Progress in Gynecology and Obstetrics," on page 22 of the January, 1935, number of CLINICAL MEDICINE & SURGERY, very much; but in justice to my very good friend, Dr. Benjamin H. Orndoff, of Chicago, I feel compelled to call your attention to his priority in peritoneoscopy, where Dr. Dorland apparently gives credit for it to Ruddock, of Los Angeles. As a matter of fact, the latter man has only rediscovered what Orndoff described nearly fifteen years ago.

May I call your attention to: "The Peritoneoscope in Diagnosis of Diseases of the Abdomen," by B. H. Orndoff, in *Journal of Radiology*, May, 1920; and "Peritoneoscope,

Pneumoperitoneum and X-Rays in Abdominal Diagnosis," by B. H. Orndoff, in *Illinois Medical Journal*, January, 1921?

I am sure that you will be glad to see that a correction of the impression, given in the paper mentioned, is made.

I. S. TROSTLER, M.D.

Chicago, Ill.

When CLINICAL MEDICINE AND SURGERY arrives each month, I first turn to the *Clinical Notes and Abstracts* for the wealth of varied, practical and condensed articles therein, and find that they are a collection of valuable material, so written that each busy practitioner and specialist will find time to read, digest and incorporate them into his daily routine.—DR. R. F. D., Illinois.

Chronic Arthritis*

CHRONIC arthritis is a systemic disease with local manifestations in the joints. The different forms of arthritis are in close connection with the different constitutional body types.

When, in the asthenic type (tall, thin persons), resistance becomes lowered because of harmful external effects, in the presence of an arthritic diathesis, a more active form of infection will appear—the rheumatoid type of arthritis, characterized by an exudative type of inflammation with proliferation of the synovial membrane and of the perichondrium. On the other hand, in the pycnic type (short, stocky persons), an arthritic infection involves a slow degenerative process, and the affected joints present a picture of a dry osteoarthritis.

From a clinical standpoint, the following factors have been shown to contribute to the development of an arthritic diathesis:

1.—Previous disease of infectious or inflammatory nature.
2.—Unfavorable climate.
3.—Damp dwellings.
4.—Lack of sunlight.
5.—Lack of exercise.
6.—Bad posture.
7.—Improper diet (lack of vitamin B combined with carbohydrate excess) and overeating.
8.—Dysfunction of the digestive system (constipation).
9.—Disturbed function of the skin (instable thermo-regulating mechanism—reduced skin elimination).
10.—Disturbed capillary blood circulation.
11.—Dysfunction of the endocrine system (ovarian—thyroid glands).
12.—Fatigue, worry, anxiety.

The combating of the disease is planned primarily through systemic measures, to which local measures are added in accordance with the prevailing signs and symptoms.

Constitutional therapy is directed towards the elimination of the arthritic diathesis, and towards the restoration of the full body vitality. It should be planned and carried out according to the different constitutional types, and should include hygienic regulation—diet, digestion, elimination, clothing, exercise, etc. —endocrine medication, as indicated, and measures to increase the circulation.

In general, the plans outlined below should be helpfully suggestive:

Constitutional Therapy in Chronic Arthritis

Rheumatoid Arthritis

(Asthenic Constitution)

Roborant and tonic therapy.

Normal caloric, low carbohydrate, rich vitamin and mineral diet.

Increase weight and fat deposits.

Stimulation of hematopoietic system; blood transfusion.

Stimulation of antibody formation (vaccine, foreign protein, fever therapy).

Relieve increased capillary and arteriolar tone (physical therapy and histamin products).

Osteoarthritis

(Pycnic Constitution)

Eliminative and reducing therapy.

Low caloric, low carbohydrate, rich vitamin and low mineral diet.

Reduce weight and fat deposits.

Deplethorizing; blood letting.

Increase excretion and secretion through diuretics, cathartics, skin irritation.

Increase circulation and metabolism (physical therapy and thyroid medication.)

Physical therapy will afford maximum benefit if it is employed early in the disease, is properly coordinated with other constitutional measures and is continued consistently for a sufficiently long period. There should be no polypragmacy, but rather a suitable alternation or combination of general and local measures. A certain change of methods is at times unavoidable in a definitely chronic condition like arthritis, hence the advantage of drawing on the large variety of circulatory stimulants offered by physical therapy.

Physical Therapy in Chronic Arthritis

I. *General or Systemic Measures*

1.—Heat: Hot water baths; electric light baths; general diathermy; hyperpyrexia treatment. Galvanic baths with or without additional skin stimulation.
2.—Heliotherapy, natural and artifical.
3.—Exercise: Carefully supervised physical training and medical gymnastics.
4.—General massage.
5.—Colonic irrigations.

II. *Local Measures*

1.—Heat: Luminous heat and infrared ra-

Arch. Phys. Therapy, X-Ray, Radium, April, 1934.

diation; diathermy; hot-air douche; monoterminal high-frequency (Oudin) current.

2.—Galvanic current. Histamin iontophoresis.

3.—Massage.

4.—Voluntary and passive exercise.

5.—Static wave current for decongestion.

6.—Low-tension wave currents for muscle exercise.

RICHARD KOVACS, M.D. and JOSEPH KOVACS, M.D.
New York City.

Stronger Solutions of Hydrochloric Acid*

WRITERS in the *Journal of the American Medical Association* have condemned the intravenous use of 1:1,500 solutions of hydrochloric acid as being dangerous, on account of the hemolysis which they assume will be produced by it. They are wrong.

A patient, under my care in the autumn of 1934, received 60 intravenous injections of 10 cc. of a 1:250 solution of this acid, with no unpleasant reactions and a striking improvement in his condition. He then suffered a relapse; but his condition again improved markedly following ten intramuscular (gluteal) injections of 2 cc. of a 2-percent solution of hydrochloric acid in 2-percent procaine solution. These injections were given slowly; the pain was negligible; and no untoward results developed.

BURR FERGUSON, M.D.
Birmingham, Ala.

Look for FACTS AND COMMENTS among the advertising pages at the back.

Liver Therapy in Anemia (Priority)

IN CLINICAL MEDICINE AND SURGERY for January, 1935 (p. 52), Harrower, of California, makes some comments on "Liver Therapy in Anemia (A Historical Note)," but he fails to refer to my publications (letters) in *The Lancet* (London), page 1248, December 1, 1934; *Science*, page 561, December 14, 1934; and *The New England Journal of Medicine* (Boston), pages 986-987, November 22, 1934.

Prof. Alfonso Pirera's articles appeared in the medical journal, *Il Tommasi* (Napoli), Vol. 7, No. 26, pages 601-617, September 20, 1912, and Vol. 7, No. 27, pages 625-636, September 30, 1912; and "*Epatoterapia ed emopoiesi epatica Anemie da disepatismo*," in *Rinascenza Medica* (Napoli), Anno XI, Nos. 22 and 23, November-December, 1934.

Professor Pietro Francesco Castellino (1864-1933), of Naples, published his paper on "*Nuove vedute sulle funzioni del fegato*" in *Nuova Vita* (Torino & Roma, Societa Editrice Nazionale Di Propaganda Igienica), Vol. 3, No. 15, December 12, 1912. Harrower's statement that, "This work was published on December 15, 1912," is an error—and he omits the reference!

Also, evidence of ignorance of the literature on this subject is the statement, "and the findings were later confirmed by a physician named Tommasi"! *Il Tommasi* (Napoli) is the name of a medical journal! Pirera is the name of the physician!

HYMAN I. GOLDSTEIN, M.D.
Camden, N. J.

Schiller's Test for Early Squamous-Cell Carcinoma of the Cervix*

THE Schiller test is for use principally in the office, in making routine or periodic examinations. If the patient comes with symptoms of cancer, she should be hospitalized and have, not only a biopsy, but a curettage for diagnosis.

Gram's Solution is used, the formula being: Iodine 1; potassium iodide 2; and water 300. The cervix is painted with this solution. When an iodine-free area is seen, a biopsy is indicated. The tissue needed is only epithelium, not the underlying tissue. It can be obtained in several ways. I prefer a small, sharp, cut-shaped tissue punch. The raw surface is then cauterized with the electric cautery. If bleeding occurs, the vagina can be packed with gauze for eight to twelve hours.

Schiller's iodine test has the advantage of being very simple, painless, requiring no special, expensive apparatus and consuming very little time. It does require some experience, however, and it also requires the assistance of a well trained pathologist, capable of making a diagnosis with small pieces of tissue.

CHARLES EDWIN GALLOWAY, M.D., F.A.C.S.
Evanston, Ill.

Killing Human Germs

CONTRACEPTION is nothing on earth but a specific prophylaxis. The spermatozoon is not a fetus, not a child, but a germ—and *germs are germs*—human, insect or botanical.

Abortion is the penalty of neglected contraception, and criminal or not, according to the statute book, it is vastly worse than harmless sanitary prevention of germ function eventuating in the fetus.

The modern movement to recognize and legalize abortions originated in Italy—of all nations in the world—and in Rome itself.

*Med. World, Feb., 1935.

*A. J. of Surg., Nov., 1934.

Balestrini was the original author and advocate. He based his thesis on humanitarianism, pure and simple.

Dr. Jean Darricarrero wrote a work, "The Law of Abortion," and declared for "woman's inalienable right to abort if she so desires."

In Russia, Artsibashoff held that the interruption of pregnancy was a mere interference with chemical reaction.

The German leadership, however, is the most logical—that no law has a right to force motherhood upon the unwilling woman. The instinct of motherhood will take care of the race suicide bogy—alarmists to the contrary notwithstanding—and it is rather astounding to realize that, as early as 1905, the Woman's Congress, held in New York (*N. Y. Journal*, 1905, Vol. 4), demanded that abortion be declared punishable only when procured by another person *against the will* of the pregnant woman.

Conscientious doctors, however, almost universally abhor the frequent, probably justifiable necessity for recourse to the extremity called abortion as a remedy for birth uncontrol; whereas contraception, in the medical purview, is scarcely more than a more diligent form of cleanliness—and cleanliness, it has been safely held, is next to Godliness itself!

HUGO FOSTER, M.D.

Chicago, Ill.

The Non-Surgical "Acute Abdomen"*

THE term "acute abdomen" is ordinarily applied to an acute abdominal condition requiring some form of immediate surgical interference to save the life of the individual or to alleviate his suffering. There are numerous non-surgical conditions, however, which present complex symptoms so closely resembling the acute surgical abdomen that we must be on the lookout lest we expose an already seriously sick patient to the added risk of surgery.

For convenience of description, these disease states may be classified as follows:

1.—Affections of the thoracic organs, such as coronary thrombosis, spontaneous pneumothorax and pleuropneumonias.

2.—Disturbances of the nervous system affecting the abdomen and its contents, such as the visceral crises of tabes, herpes zoster, intercostal neuralgia and lead colic.

3.—Rheumatism, allergy and acute infectious diseases.

4.—Arteriosclerosis of the abdominal vessels, including arterial thrombosis and vascular spasm.

5.—Displacements and irritative conditions of some of the abdominal organs, such as twisting of a renal pedicle, urinary tract inflammations and gastro-intestinal manifestations. The latter may include pylorospasm, intestinal colic, indiscretions in diet and mucous colitis.

6.—Intoxications and constitutional diseases. The more important conditions under this heading are diabetic ketosis, uremia, sickle-cell anemia and alcoholism. Alcoholic intoxication may give acute abdominal symptoms of the surgical type.

LOUIS H. SIGLER, M.D., and
PHILLIP I. NASH, M.D.

Brooklyn, N. Y.

*Med. Times and L. I. M. J., Nov., 1934.

The Intravenous Use of Emetine Hydrochloride*

AFTER a considerable amount of experimentation, I have found that 0.06 Gm. (approximately one grain) of emetine hydrochloride, in 6 cc. of triple-distilled water, gives the best results. In amebic dysentery I inject one 6 cc. ampule intravenously, daily for ten days, then give a week's intermission. The same dose is used in ulcerative colitis. For duodenal or peptic ulcer I inject one 6 cc. ampule every other day until six have been administered, and then give a week's intermission, after which, if necessary, I give three more injections. I have never found that more than nine injections were required to effect a complete cure. While the injections are being given I place the patient on a bland, salt-free diet of milk, eggs, cream, cheese, custards, white bread, sweet butter and cream soups. Alcohol in any form is strictly prohibited.

A. E. OLPP, M.D.

Union City, N. J.

*Med. Rec., Nov. 7, 1934.

Intradermic Injections

IN spite of the fact that intracutaneous injections have been in use for a number of years, for diagnosis (as in the Schick, Dick and luetin reactions, tests for allergy, etc.) and treatment (as in the case of the gonococcus bouillon filtrate of Corbus and Ferry), there are still many physicians who do not thoroughly understand the technic of giving these injections in the proper manner, and who, in attempting to give them, are prone to give a hypodermic injection instead, which by no means serves the same purpose.

Intradermic injections (as the name implies) are given, not *under*, but *into* the layers of the skin. The doses used are so small that a tuberculin syringe, graduated, at most, in twentieths of a cubic centimeter, should be used for measuring and administering them.

It is important to use a fine needle (preferably 25 gage), which is also very sharp and free from "hooks" and other irregulari-

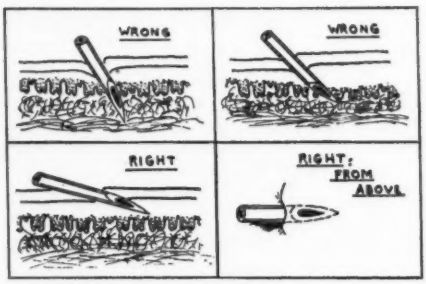

Fig. 1: Diagram of the Technic of Intradermic Injections; adapted from the *Journ. Indiana State Med. Assn.*, 23:320, 1930.

ties. This should be introduced parallel to the skin surface, with the beveled side upward, taking care to advance the needle slowly and to penetrate the papillary layer to a depth of less than one millimeter. When this is done properly, the distal end of the needle can generally be seen dimly through the epidermis (see Fig. 1).

The extensor surfaces of the forearms and thighs are the best places for making these injections. In female patients, for cosmetic reasons, the thighs or abdomen should be used, as "pitting" may occasionally occur in cases of positive reactions.

When the injection has been correctly placed, a dimpled wheal appears, which is not translucent, but white and sharply circumscribed, with a rose-pink border.

Those who are not familiar with the technic of giving intradermic injections will do well to practice it on their own bodies a number of times, using sterile, physiologic salt solution, before attempting it on a patient.

Chicago, Ill. GEORGE B. LAKE, M.D.

Bismarsen in Neurosyphilis*

BISMARSEN is probably one of the most effective drugs in the meningeal type of neurosyphilis. In some cases, meningeal symptoms develop during therapy, and in these instances continued treatment will prove of definite benefit.

If arsenic is to be employed at all in the vascular type, Bismarsen should be the drug of choice. This is given intramuscularly, in doses ranging from 0.1 to 0.2 Gm. once weekly, over a period of 10 to 20 weeks. This constitutes the usual procedure. Several courses should be administered, provided no untoward symptoms develop during the treatment. Treatment in the vascular cases must be continued more or less indefinitely.

Bismarsen is a combination of bismuth and arsenic. Its use in tabes has been productive of some excellent results, especially from a symptomatic angle. Bismuth, alone or in combination with one of the arsphenamines, has not produced results equalling those following the use of Bismarsen.

In the case of a young woman with marked ataxia, necessitating the use of support and with almost total loss of control in her lower limbs, several courses of this drug were administered; she responded to such an extent that she was able to walk without any support and to control her lower extremities with a remarkable degree of accuracy.

In another instance, a patient with severe lightning pains was entirely relieved by the use of this drug, after narcotics and sedatives had been employed for years without success.

THEODORE C. C. FONG, M.D.
Washington, D. C.

*Med. Ann. Dist. of Columbia, V. 3, No. 8, August, 1934.

When Should a Senile Cataract Be Removed?*

EXPERIENCE and diagnostic skill are necessary to determine the type and degree of maturity of any senile cataract. When both eyes are involved and the patient is unable to work, other things being favorable, the intracapsular method of removal is to be preferred. Only one eye at a time should be treated. When one eye is affected and the other has good function, the ideal time for operation is when the lens is completely opaque and the anterior chamber of normal depth. When the cataract is caused by, or incident to, constitutional disease, careful consideration must be given to such complicating factors, and, finally, the diagnosis of senile cataract is made most accurately after slit-lamp examination.

ARTHUR J. BEDELL, M.D., F.A.C.S.
Albany, N. Y.

*New York St. J. Med., 34:801, Sept. 15, 1934.

Psorimangan in Psoriasis and Ichthyosis

(Case Reports)

I HAVE nothing new to offer as to the cause of the rather common disease, psoriasis, but wish to report the spectacular response to the use of Psorimangan in a case of 5 years' duration:

Miss G., age 23, blonde; family history negative; body covered with approximately 300 psoriasis lesions, varying in size from that of a pea to a half-dollar. The patient had been treated by several physicians, with only temporary relief.

She presented herself to me May 29, 1934. As she had tried almost everything else, I suggested that we try Psorimangan, a colloidal manganese. I started the treatment with 1 cc. intramuscularly, in the gluteal re-

gion, and repeated this dose once weekly for 5 doses. After the third injection the lesions began to fade, and after the fifth injection they had all completely disappeared, with no return up to the present time—some 5 months after the last injection. There were no systemic reactions.

While I realize that one case does not prove anything, the ready response in this patient makes the remedy worthy of a trial in all cases of psoriasis.

The therapeutic effect of Psorimangan is explained by van Kerkoff, the dermatologist of Leiden, on the hypothesis that colloidal manganese actually possesses the property of exercising an activating effect upon the fermentative oxidation process within the cells of the epidermis. This view is also held by Pautrier, who believes that manganese does not yield oxygen directly, but acts only as a catalytic agent during the oxidation process.

Ichthyosis

The action of Psorimangan, in the case of psoriasis just reported, led me to believe that it would prove valuable in other skin conditions, and I have now under experimental treatment a classical case of ichthyosis, congenital type, of 32 years' duration.

Miss S., age 32, states that a skin condition appeared in the first year of her life. The family history is negative. This patient received two 1 cc. intra-gluteal injections of Psorimangan, weekly for 17 weeks. At the end of that time there was a noticeable lessening of the scaling and thickness of the epidermis and, for the first time in her life, perspiration appeared in several areas of the face and back.

During the eighteenth and nineteenth weeks, the dose of Psorimangan was increased to 4 cc. weekly, one injection of 2 cc. being given intramuscularly, followed in 3 days by another 2 cc. given intravenously. Since then (for the past 2 weeks) she has had one 2 cc. injection intravenously twice a week.

Up to the present time, Miss S. has had thirty-five 1 cc. intramuscular injections; two 2 cc. intramuscular injections; and six 2 cc. intravenous injections of Psorimangan, without systemic reactions of any kind. Her body is clear of thickened epidermis and scales, with the exception of the face, knees and elbows. Frequently the scales on these areas disappear for a few days at a time, and each time they reappear they seem to be thinner.

C. R. PERDUE, M.D.

Indianapolis, Ind.

If I could have but one medical journal, I should choose CLINICAL MEDICINE AND SURGERY, as being the most helpful for the general practitioner.—W. E. E. T., M.D., Michigan.

The Thymus and Status Thymico-Lymphaticus*

MORE and more reports indicate that careful postmortem examination would eliminate from the category of "thymus deaths" many cases formerly so classified. The weight of recent evidence, too, whether obtained by anatomic or roentgenologic study, is against any correlation between undue oversize of the thymus and sudden death.

The merits of the demonstration of thymic enlargement on the roentgenogram must depend upon a correct evaluation of the size, shape and position of the organ in normal infants, and in addition the effect produced by respiration and the position of the patient. Most clinicians would agree that roentgenograms, taken casually and only during one phase of respiration, furnish little information concerning the size of the thymus. More work is needed to establish average boundaries, and this is rendered difficult by the fact that the normal size of the organ at any age in infancy or childhood is decidedly variable, and also that there are racial and geographic differences. That is to say, it cannot be stated that a shadow greater than a certain width is necessarily indicative of thymus enlargement, nor that it proves that obstructive symptoms are due to this. In fact, the roentgenogram may not infrequently disclose a greatly enlarged thymus when no symptoms are present. Probably something can be learned from lateral views concerning compression of the trachea. Perhaps it is fair to state that clinical symtoms are of as much, if not more, value in the diagnosis of thymic pressure than are roentgenograms, unless the latter are taken and interpreted by experts with experience.

Mathematical study has been carried out on a group of 116 infants and children who, according to roentgenograms, had an enlarged thymus, using as a control group 81 infants and children who did not have an enlarged thymus by the same criterion. Clinical impressions previously held were strengthened by the analysis. It would appear that certain statements can be made with reasonable assurance.

1.—In some instances an enlarged thymus gland can cause pressure upon structures in the thoracic inlet and lead to the development of such symptoms as dyspnea, suffocative attacks, crowing respiration, cough and cyanosis.

2.—The symptoms mentioned occur with many other diseases and abnormal conditions, and these are perhaps more frequent causes of all of them than is enlarged thymus.

3.—An infant or child who has some cause for dyspnea, cough and cyanosis, as res-

*Ann. Int. Med., Dec., 1934.

piratory tract infection, congenital heart disease and the like, and who also has an enlarged thymus, is more liable to develop these symptoms. Probably an enlarged thymus may aid in their production, even in instances where, in itself, it would be insufficient to cause symptoms.

4.—From a mathematical point of view, there is no significant association between enlarged thymus and pylorospasm.

5.—There is no proof that convulsions are associated with enlarged thymus, and their presence, even in a patient with an enlarged thymus gland, should lead to a suspicion that increased intracranial pressure, spasmophilia (tetany) or some other cause exists.

6.—An enlarged thymus, according to roentgenograms, is by no means necessarily associated with symptoms.

7.—Even when obstructive symptoms are present in an infant or child with an enlarged thymus, search must be made for other possible causes.

8.—This study furnishes no solution to the question of the relation of sudden death, not explicable by some discoverable cause, to status thymico-lymphaticus.

A. GRAEME MITCHELL, M.D., F.A.C.P.,
and ESTELLE W. BROWN, B.S.
Cincinnati, O.

Abdominal Pain*

MOST investigators feel that there are few, if any, true pain fibers in the nerves supplying the abdominal organs. In our analysis of the cause of abdominal pain, perhaps our best explanation is that abdominal impulses may result in referred pain—the visceral sensory reflexes; tenderness, that is, cutaneous or muscular hyperalgesia; and muscular contractions, that is, muscle spasm.

In analyzing and interpreting abdominal pain we have to consider physiologic unbalance, organic pathology, local or general hypersensitiveness, the overlapping and confusion of symptoms due to similar nerve supply and close proximity of organs—the whole modified to a tremendous degree by the emotional stability or instability of the patient.

There is, unquestionably, too great a tendency at the present time to lean too heavily upon laboratory methods and too lightly upon pure clinical observation. If we recognize this unbalance and, while not neglecting the results of laboratory methods, which are invaluable, attempt to recapture the marvellous clinical sense, the wonderful powers of observation and analysis of the great clinicians of the past, we may reach the point where we can say, "The history of the case should give us our correct diagnosis; the physical examination and laboratory tests should be merely confirmatory." We are simply stating that, at the present writing, the science of medicine alone, the results of clinical laboratory and x-ray studies, at least in the abdominal field, are not sufficient to lead to a correct diagnosis in most cases. It means that we must not discard the art of medicine and that the microscope, the test tube, the instruments of precision and the x-rays cannot as yet displace the eye, the ear, the finger, and the results of observation.

THOMAS R. BROWN, M.D.
Baltimore, Md.

*Ann. Intern. Med., 8:343, Sept., 1934.

Diagnosis of Coronary Occlusion*

ABOUT eight or ten years ago, at a time when I was much interested in the clinical manifestations of coronary occlusion, I was often asked to see patients with symptoms of collapse following a severe attack of pain in the chest, and under these circumstances had the satisfaction of pointing out how simply and clearly the diagnosis of coronary occlusion could be made. However, these opportunities have come very, very rarely during the past few years. At the present day the humblest practitioners of medicine and the most recent graduate are so thoroughly familiar with the picture of this tragic event and so acutely alive to its recognition that the opinion of a consultant is seldom needed to suggest the diagnosis. Indeed, the diagnosis is frequently and readily proposed, and having passed through the earlier period when it was seldom even thought of, I am now often surprised by being asked to see patients with coronary occlusion who are really suffering from some other disorder.

It is astonishing how information about this condition has spread through the profession and with what eagerness and enthusiasm the knowledge has been applied. Now, when almost every sudden, severe pain in the chest, in a person past middle life, is at once called coronary occlusion, seems the appropriate time to sound a warning. There are other diseases of the heart, lungs and abdominal organs which may so closely resemble coronary occlusion that they are often distinguishable from it only with great difficulty and sometimes not until autopsy discloses the real state of affairs.

The five conditions which in my experience have occasionally been confused with it are: upper abdominal disease; pericarditis; pulmonary embolism; rupture of the aorta; and interstitial emphysema of the lungs.

LOUIS HAMMAN, M.D., F.A.C.P.
Baltimore, Md.

*Ann. Int. Med., Oct., 1934.

THUMBNAIL THERAPEUTICS

Blood Pressure in Spinal Anesthesia

AS I look at the problem of the blood pressure in spinal anesthesia we have three phases to consider: We know that normal blood pressure is maintained by the output of the heart, the peripheral resistance of the arterial bed, and the volume of the blood. Ephedrine helps in maintaining the peripheral resistance; preventing the anesthetic from ascending above the 4th thoracic nerve preserves the heart action; and the blood volume may be controlled by phleboclysis with dextrose solution. This last measure has been of great help in spinal anesthesia. If the average individual has about five liters of blood, and we add another liter to this volume, it is easily understood how we can bolster up the blood pressure.—W. L. WANER, M.D., in *Bul. Evanston Branch Chicago Med. Soc.*, Feb., 1935.

Hydrochloric Acid in Tonsillitis

IN acute tonsillitis, intravenous injections of hydrochloric acid act like a specific. Give two injections, on two succeeding days (no more) of 10 cc. of a 1:1,500 or 1:1,000 solution of the acid, and on the third day the patient is ready to go to work. Sometimes one injection is enough.—DR. WILLIAM I. HOWELL, in *Med. World*, Jan., 1935.

Tic Douloureux

TIC DOULOUREUX or trifacial neuralgia can generally be relieved (sometimes permanently) by repeated inhalations of trichlorethylene. This method will, in some cases, obviate the need for surgical procedures and is practically without danger. It should be tried in all cases before resorting to surgery. —DR. MARK A. GLASER, in *West. J. Surg. Obst. & Gyn.*, Dec., 1931.

Preoperative Preparation

IN preparing patients for anesthesia and operation, better results may be obtained if fear and apprehension are allayed. This may be done conveniently by administering a barbiturate in small doses, for example, 0.2 Gm. of Sodium Amytal at bedtime the night before the operation, and then by repeating this dose when the patient wakes up in the morning. About forty-five minutes before the operation, 0.01 Gm. of morphine and 0.4 mg. of atropine are administered hypodermically. In addition to adding to the patient's mental comfort there is the advantage that less general anesthesia is necessary, as a rule, than when preliminary medication is not used.—JOHN S. LUNDY, M.D. and RALPH M. TOVELL, M.D., in *Northwest Med.*, Sept., 1934.

Treatment of Leukorrhea

I HAVE found the following procedure of real value in vaginal leukorrhea:

The vagina is thoroughly dried. A tablespoonful of granulated sugar is put on a small piece of paper, and a teaspoonful of an ointment containing acid salicylic., 10 grains (0.65 Gm.); ung. hydrarg., U.S.P., 2 drams (8.0 Gm.); and ung. zinc. oxid., to make 1 ounce (30.0 Gm.) is rolled in it, and both the sugar and ointment are introduced into the vagina, followed by a tampon. The tampon is removed in 24 hours and no douche is necessary. The sugar and ointment produce a syrupy mixture which is highly bactericidal and is effective for about a week. —ADOLPH REICH, M.D., in *A. J. Surg.*, Sept., 1934.

Infection in the Male Pelvis

THE male pelvis is only rarely infected and, when it is, the space of Retzius is usually meant. The treatment is entirely surgical; incision, suprapubic drainage and, at times, counter drainage from the perineum. —DR. G. GREENBERG, of New York, in *M. J. & Record*, Oct. 5, 1932.

Blood Transfusions

ATTEMPTS to retard coagulation by the addition of drugs impair the value of the blood from the biologic and immunologic point of view. Many clinicians claim that anti-coagulant drugs reduce the phagocytic and opsonic powers of the blood and increase the fragility of the erythrocytes. Sodium citrate leads to destruction of blood platelets. The whole-blood method has the additional advantage of being followed by fewer post-transfusional reactions. The latter occur in about 35 percent of citrated-blood transfusions, and in only about 15 percent or less of unchanged blood transfusions.

Transfusions should be performed with speed. In fact, speed in this procedure is the keystone of success, and delay predisposes to clotting, the great stumbling block of

whole-blood transfusions. In arteriosclerotic patients and in those who show marked myocardial impairment, it is advisable that the injection be made slowly. If at any time during the transfusion the recipient complains of marked dyspnea, cervical constriction, precordial distress or shows signs of anguish, the injection is to be stopped immediately.—Dr. A. P. Heineck, of Chicago, in *Med. Herald*, Sept., 1932.

Acute Articular Rheumatism

IN acute articular rheumatism, the most important point is to keep the patient in bed, not merely until the fever is gone, but until the heart is normal—possibly for months.—Dr. Bernard Myers, Royal College of Physicians, London, Eng.

Gastric Lavage in Diabetic Coma

ALWAYS wash out the stomach of a patient in diabetic coma. The entrance of stomach contents into the trachea and lungs (which easily occurs in this condition) may have disastrous consequences.—Dr. E. P. Joslin, of Boston.

Preventing Peritonitis

IN all abdominal operations, *extreme gentleness* should be used, so as to avoid, in all possible ways, damage to the tissues, which predisposes to the development of peritonitis. Dr. Vernon C. David, Rush Medical College, Chicago.

Prostatic Conditions in the Aged

FOR elderly prostatic patients, who can void but do not entirely empty their bladders, occasional catheterization and irrigation with such a lotion as potassium permanganate, 1:8,000, is usually the most satisfactory procedure. The optimal frequency must be determined by experiment.—Dr. S. W. Moorhead, of Philadelphia, in *M. J. & Record*, Oct. 5, 1932.

Insulin in Thin Persons

INSULIN will increase the weight of unduly thin, non-diabetic persons. The usual dose is 10 units, administered by the patient himself, 20 to 30 minutes before meals. The diet is liberal and unmeasured. The weight thus gained is usually held rather well after the injections of insulin are discontinued.—Dr. Harry Blotner, in *J. A. M. A.*, Jan. 14, 1933.

Treatment of Early Syphilis

WHEN the antisyphilitic drugs are continuously administered, so that the course of arsphenamine is immediately succeeded by and alternates with the course of heavy metal (bismuth or mercury), the treatment is more than twice as effective in the group given 20 or more doses each of arsphenamine and a heavy metal as in the group given less than this number. If the courses are given intermittently or if treatment is irregular, treatment consisting of 20 or more doses each of arsphenamine and a heavy metal is from 4 to 5 times as effective as a smaller amount. Patients who had received this minimum of treatment by the continuous scheme were subject to relapse only one-third as often as those who had received less than 20 doses each of the arsenical drugs and the heavy metal, within one year after making the diagnosis. — *Venereal Disease Information*, Oct., 1934.

Intraventricular Injection of Epinephrin

THE intraventricular injection of epinephrin gives a violent stimulus to the heart that is very effective and has largely displaced cardiac massage in emergencies. A 22-gage needle, 9 cm. long, is inserted at the left border of the sternum in the third interspace, carried in mesially until the resistance of the ventricular wall is past, aspirated to prove that the point of the needle is in the free ventricular cavity and the withdrawn blood reinjected with 5 to 10 minims of epinephrin, in the Luer syringe.—Dr. W. W. Babcock, in *Am. J. Surg.*, Aug., 1932.

Thyroid Disease and Chronic, Nonspecific Arthritis

DIVERGENT manifestations of thyroid dysfunction are productive of articular disturbances that can be looked on as being characteristic of these altered physiologic states. Hyperthyroidism is accompanied by capsular and periarticular changes which, if inadequately treated, lead to atrophic polyarthritis with characteristic contractures. These changes are highly amenable to well directed surgical measures on the thyroid. Articular manifestations of hypothyroidism are degenerative, are slowly progressive and are readily lessened in severity by the administration of thyroid extract in adequate dosage.—Dr. W. A. Duncan, of Cleveland, in *J.A.M.A.*, Oct. 8, 1932.

NEW BOOKS

Any book reviewed in these columns will be procured for our readers if the order, addressed to CLINICAL MEDICINE AND SURGERY, Medical & Dental Arts Bldg., Waukegan, Ill., is accompanied by a check for the published price of the book.

There is no business, no avocation whatever, which will not permit a man, who has the inclination, to give a little time, every day, to study.—DANIEL WYTTENBACH.

Spiers: Fractures

A BRIEF OUTLINE OF MODERN TREATMENT OF FRACTURES. *By H. Waldo Spiers, A.B., M.D., Professor of Orthopedic and Fracture Surgery, College of Medical Evangelists, Los Angeles, California. Baltimore: William Wood & Company. 1935. Price, $2.00.*

The rising tide of automobile accidents and industrial injuries is flooding the profession with fracture cases, some of them simple, some calling for the most skillful yet prompt judgment as to the best method of treatment.

It is most essential, not only to diagnose speedily and correctly, but to know thoroughly the fundamental principles of all fracture surgery, as well as the most successful modern methods of treatment. Bulky textbooks provide so many non-essential details and alternative methods as to be confusing. Mere diagrams or atlases do not supply the why and wherefore.

Dr. Spiers, in this book, strikes the happy medium, and refreshes your memory as to fundamentals, while he also points out and describes the best and most recent well-proved methods of treatment—methods which you can apply. This little book, with its 108 clear-cut line drawings and crisp, concise descriptions, will give you, in the shortest possible time, a complete review, a fresh grasp of and a new insight into the whole subject of fracture treatment. It will be of such great value to general clinicians and students that its very moderate cost will be negligible.

Kemp: The Art of Medicine

HOW TO PRACTICE MEDICINE. *By Henry W. Kemp, M.D. New York: Paul B. Hoeber, Inc. 1935. Price, $2.50.*

The medical schools, today, are so busy cramming their students with the *science* of medicine, that they seem to have no time for nor interest in its *art*, which, if one is to be a successful clinician (as most medical students hope to be), is equally or more vital.

If the newly graduated physician, or some of the unsuccessful older ones, could receive the advice and counsel of an experienced and highly successful practitioner, and then *follow it*, the value of such assistance would be incalculable.

Here is just that very thing! A man who knows, telling, in direct and specific detail and in language like a spicy and fascinating conversation, just how to find out what type of medical work one is fitted for; how to choose a location; how to equip an office (including the reception girl), dress and conduct oneself; how to conduct office and house calls, with men, women and children; how to secure cash payments for services rendered and keep good patients; how, when and why to write prescriptions; the values of professional and fraternal societies and church relationships; the management of chronic and referred cases; and score of other matters, a proper understanding of which is vital to success in clinical practice.

It is not too much to say that the repeated study and *practice* of the suggestions contained in this delightful little volume will enable any recent graduate to lay the foundations for a professionally and economically satisfactory practice, or any practitioner, whose income is less than $3,000 a year, to double that income.

No similar book is presently available, and it would be difficult to praise this one too highly.

Tidy: Medicine

A SYNOPSIS OF MEDICINE. *By Henry Letheby Tidy, M.A., M.D., B.Ch. (Oxon.), F.R.C.P. (Lond.), Physician to St. Thomas's Hospital; Consulting Physician to the Royal Northern Hospital; etc. Sixth edition, revised and enlarged. Baltimore: William Wood and Company. 1934. Price, $6.00.*

The fifth edition of this highly valuable work was reviewed in these columns in January, 1931 (page 77), and all the good things then said of it can be cordially repeated, with emphasis, because this sixth edition is even better, and seventy-five pages larger, than its worthy predecessor.

Many chapters, including those on Deficiency Diseases and Vitamins; Nephritis; Anemia; the Endocrines; Glandular Fever; Diseases of the Bones; and a number of others, have been almost entirely rewritten and generally enlarged. In the fifth edition,

the Parathyroids were dismissed with fifteen *lines;* in this, that section occupies thirteen *pages.*

A number of new articles appear here for the first time: Hypoglycemia; Herpes Labialis; Anemias of Pregnancy; Acute Adrenal Insufficiency; etc.

This is not, of course, a textbook of medicine; but it is so vastly more than a quiz compend that it occupies a unique place in the library of every practicing clinician. It is a volume to be kept at the doctor's elbow at all times and will, in 99 percent or more of occasions, give him exactly the information he needs on the spur of the moment. Those who have used the earlier editions, have found them indispensable and will not feel that they can *afford* to be without this one.

Considering the compactness of the volume, the information presented is astonishingly complete and reliable, and is arranged to facilitate quick reference, with a double-column, 55-page index to guide one promptly to the information sought.

Alexander: Success

THROUGH FAILURE TO SUCCESS. *By James Alexander, Author of "Thought-Control in Everyday Life," "Mastering Your Own Mind," etc. Literary Digest Books. New York and London: Funk & Wagnalls Company. 1934. Price, $1.50.*

This volume, simply written and evidently for popular reading, gives a common sense outlook on the theory of success and how one may more easily direct one's life in that direction. The author makes no attempt to theorize or to discuss at any length the advice he gives. Simple facts, rules and observations are presented in such a manner that discussion becomes unnecessary, because of the evident truth of the statements made. To emphasize the material, many interesting incidents from the lives of prominent men are cited, to show how they prepared themselves for their attainment of success.

The book, which appears to be a rather hastily assembled collection of old material, should be of special value to the person interested in overcoming timidity and controlling fear, self-consciousness, nervousness and other similar handicaps.

J. R. C.

Siegel: Eugenics

CONSTRUCTIVE EUGENICS AND RATIONAL MARRIAGE. *By Morris Siegel, M.D. Toronto: McClelland & Stewart, Ltd. 1934. $2.50.*

Less than one-tenth of one percent of the people in this country (including physicians) know anything about the science of eugenics, beyond the name of it. This is probably the result of the fact that there have, hitherto, been few or no *readable* books on the subject.

Dr. Siegel has done a service in presenting the matter in an interesting form and in language so clear that it can be understood by any high-school senior.

After setting forth, in an intelligible way, just what eugenics does and does not mean, he gives, in the second part of his discussion, his views as to how the people can be made eugenically-minded. The keystone of the program is, of course, education—in elementary schools, in undergraduate and graduate medical schools and by means of propaganda. He emphasizes the fact that "social hygiene" is merely a corollary of eugenics, and that this latter can be taught where the former might be inadmissible.

Every physician, teacher, parent, clergyman and social worker should be familiar with the ideas presented by Dr. Siegel.

Knaus: Physiologic Contraception

PERIODIC FERTILITY AND STERILITY IN WOMAN. A Natural Method of Birth Control. *By Professor Hermann Knaus, Head of the Clinic for Gynecology and Obstetrics of the German University of Prague. With a Foreword by F. H. A. Marshall, F.R.S. Authorized English Translation by D. H. Kitchin, of Gray's Inn, Barrister-at-Law, and Kathleen Kitchin, M.Sc., M.B., B.S., London. With 64 Illustrations and 12 Tables. Vienna: Wilhelm Maudrich, Publisher. Obtainable for United States and Canada from the Concip Company, Hobart, Indiana. 1934. Price, $6.50.*

In this volume, the complete scientific basis underlying the theory of the periods of fertility and sterility in women is made available, under one cover, for the first time.

Dr. Knaus has set forth, in this well made and amply illustrated book, not only the conclusions at which his observations forced him to arrive and the practical methods for applying these conclusions, but also the elaborate and meticulously checked details of these observations, with discussions of their significance.

He gives space to reprinting the statements of those who disagree with him, and then proceeds, coolly and impartially, to point out the errors in their observations or reasoning or both. A bibliography, occupying 14 pages, is appended.

After reading this fully documented and closely reasoned discussion, it is almost impossible to escape the conclusion that healthy and regularly menstruating women have a definite period in each month, during which pregnancy is, to all intents and purposes, impossible; and this in spite of whatever prejudices or biases of thought the reader may have entertained in the past.

While it seems quite possible that one or another of the brief publications which set forth the technic of the practical application of the socalled Ogino-Knaus theory may be sufficient to enable most intelligent women to carry out this method satisfactorily, the truly scientific physician will want and need this authoritative source-book of fundamental material, written by the man who seems to have priority in the direct presentation of the idea, at least among Europeans. It represents a vast amount of labor and thought, in the gathering and presentation of the material.

Though the price may seem high for a volume of but 160 pages, one must remember that it was published abroad; written in German and translated; is well printed and substantially bound; and required a long time for its preparation, writing and correlation. No scientific library should be without it, as it will be effectively useful to all who study seriously in this line. Moreover, physicians generally will find it a mine of information, which seems to be bound to be called for with increasing frequency and insistence in the future, unless further and wider experience should upset the theory — which now seems unlikely.

New Webster's Dictionary

WEBSTER'S NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE. *Second Edition, Unabridged. William Allan Neilson, Ph.D., LL.D., L.H.D., Litt.D., Editor-in-Chief; Thomas A. Knott, Ph.D., General Editor; Paul W. Carhart, Managing Editor. Springfield, Mass.: G. & C. Merriam Co. 1935. Price, Buckram, $20.00; Sheep, $25.00; Buckram with India Paper, $27.50; Full Leather, Seal Grain, with India Paper, $35.00.*

The past 25 years have witnessed an evolution in man's practical and cultural knowledge, comparable to that in no other period in the history of civilization. Twenty-five years ago there was no radio, aviation was in its infancy, America had no income tax, insulin had not been discovered, the World War had not yet convulsed civilization and changed the map of the world. Webster's New International Dictionary, truly called the foundation book of education, had to be remade to comprehend these vast changes. No revision was adequate. A *new book* has been created, which is the key to the vastly greater cultural and practical knowledge that is mankind's today.

This great volume contains over 600,000 entries—the greatest amount of information ever put into one volume. It is profusely illustrated. It contains thousands of encyclopedic articles and hundreds of useful features of great practical value. These and many other features make this epochal book a complete general dictionary for home, school and office, and a comprehensive special dictionary in many fields of thought and activity.

G. L., Jr.

Sigerist: American Medicine

AMERICAN MEDICINE. *By Dr. Henry E. Sigerist, the William H. Welch Professor of the History of Medicine, the Johns Hopkins University. Translated by Hildegard Nagel. New York: W. W. Norton & Company, Inc. 1934. Price, $4.00.*

This book is an account of the rise and progress of American Medicine from the earliest times to the present. It opens with a graphic picture of the curious customs of the medicine men of the Indian tribes who preceded the white men on the continent, and then, in historical sequence, traces the practice of medicine from the necessarily primitive methods of Colonial days to the highly developed specialization of our times. An attractive feature of the book is the section on pioneers, presenting illuminating biographies of the great figures in American Medicine, from Rush and Drake and Beaumont, through the intermediate period of Gross and Sims and S. Weir Mitchell, down to Billings and Osler. Special sections are devoted to Medical Education and the development of medical schools and colleges; to the Physician and the Patient, and to the growth of Hospitals and Nursing. The concluding chapters tell the story of the amazing strides which this country has made in Preventive Medicine and in the more highly scientific aspects of medical knowledge. There is a comprehensive bibliography and two indexes, one of persons and one of subjects.

Hayes Druggists' Directory

THE HAYES DRUGGISTS' DIRECTORY AND COMMERCIAL REFERENCE BOOK, 1934. *Detroit, Michigan: Edw. N. Hayes, Publisher. Price, $9.00.*

This directory gives a full and complete list of all the druggists in the United States, with their financial standing and credit rating, as well as a separate list of wholesale druggists. The chain stores are listed in this directory, with the addresses of their buying headquarters and the number of stores they operate.

The 1934 book lists, all told, 53,316 druggists, operating nearly 60,000 stores. The directory has been issued annually for the past twenty years, and furnishes information not available elsewhere.

Bell: Search for Truth

THE SEARCH FOR TRUTH. *By Eric Temple Bell, Professor of Mathematics, California Institute of Technology; Member National Academy of Sciences; Past-President Mathematical Association of America. Baltimore: The Williams & Wilkins Company. 1934. Price, $3.00.*

In this book the clever and versatile author has, in the name of "straight thinking," set out to prove that all the men who, from the beginning of history, have been looked upon as wise, strong and good, were crooked thinkers, if not puerile morons, deluding themselves out of sheer assininity, or their followers for what they could make out of them. If saltily phrased dogmatism and wise-cracks are proof, the vote should go his way by acclamation.

Being a mathematician of note, who appears to be proud of his rather rabidly materialistic outlook on life, he feels it necessary to lump philosophy, metaphysics and mysticism in the same category as quibbling and superstition, and class them all as mushy and moronic balderdash. Nor are his far-from-fully-informed tergiversations any the more acceptable because he generously admits (or declares), in the first chapter, that "Mathematics does not create new truths; it produces an endless string of tautologies."

Some people of sound and active intellect, who have read widely and with discriminating perception, may grow a bit weary of seeing all whose past statements do not agree with the present self-satisfied position of Professor Bell, characterized as nitwits, muddy thinkers, knaves or fools—or words to that effect.

All in all, those who feel that there is nothing to a man but his meat; that, in accordance with a statement attributed to Nietzsche, "Christianity is the foulest blot on our civilization"; that nothing is real or valuable which cannot be weighed, measured and analyzed by strictly physical methods, will find this volume a "smart" and probably a pleasing rationalization of their position. Those who have lived more widely and deeply will discover that this "Search for Truth" has uncovered nothing which will add to their wisdom, their happiness or their value to themselves or others.

Hess, Mohr and Bartelme: Premature Children

THE PHYSICAL AND MENTAL GROWTH OF PREMATURELY BORN CHILDREN. *By Julius H. Hess, M.D. Professor of Pediatrics, College of Medicine, University of Illinois, Chicago, Attending Pediatrician, Illinois Research, Cook County and Michael Reese Hospitals; George J. Mohr, M.D., Director, Pittsburgh Child Guidance Center, Formerly Research Psychiatrist, Behavior Research Fund, Institute for Juvenile Research, Chicago; Phyllis F. Bartelme, Ph.D., Psychologist, Cook County Juvenile Court, Chicago Research Psychologist, Institute for Juvenile Research. Chicago: The University of Chicago Press. 1934. Price, $5.00.*

This work is a summary of the case records of almost 2,000 children cared for in the Premature Infant Station of the Sara Morris Hospital of Michael Reese Hospital during the past twelve years. Beginning with a study of the parents themselves, causes of premature birth, type of delivery, and condition at birth, these children have been followed through the years to ascertain their physical and mental development, habit formation, and social adaptation. This book will be of interest to psychiatrists, psychologists and all concerned with child welfare.

Kagan: Jewish Physicians

JEWISH CONTRIBUTIONS TO MEDICINE IN AMERICA (1656-1934). With Medical Chronology, Bibliography and Sixty-nine illustrations. *By Solomon R. Kagan, M.D. Boston: Boston Medical Publishing Company. 1934. Price, $4.00.*

This book is practically a "Who's Who" of prominent Jewish physicians in the United States and may be of value as a reference work, for those who are interested in medical biography.

Robinson: The Safe Period

THE SAFE PERIOD, or The Natural Method of Birth Control. *By Dr. William J. Robinson, Author of more than 30 books, Editor of "The Medical Critic and Guide," and Fellow of the New York Academy of Medicine; Fellow of the American Medical Association; International League for Sexual Reform; British Society for the Study of Sex Psychology; American Association for the Advancement of Science, etc. New York: Eugenics Publishing Company. 1935. Price, $0.10.*

Dr. Robinson, who is a well known authority on sex matters, has prepared a little brochure of 16 pages, written for laymen, in which he states that, while the "safe period," as worked out by Ogino and Knaus, is not 100 percent safe in all cases, it probably is reliable in the majority of women whose genital organs are normal and whose menstrual periods are regular. Where the avoidance of conception is imperative (and in other cases, when practicable) he feels that a reliable contraceptive jelly should also be used.

This is a valuable booklet, which physicians may well distribute (if they feel so disposed), as a public service. The only way they will profit by such distribution is through the good will which may be engendered.

Heart

HEART. Signs of Agni Yoga. *310 Riverside Drive, New York City: Agni Yoga Publications. 357 pages. Price, $1.00.*

This latest of the Agni Yoga (Union by Fire) Series (the former ones, "Agni Yoga" and "Hierarchy," having been reviewed in these pages formerly) is another surprising collection of penetrating metaphysical philosophy, esoteric science and memorable epigrams.

The "heart," as conceived by its author or authors, is not the physical organ, but "the sun of the organism, the focus of psychic energy." And yet there are many passages here and there which have definite clinical connotations, if rightly understood. For example:

"The psychic energy is simply devoured by doubt."

"Without exaggeration one may say that the majority of heart diseases originate because of wealth."

"Suggestion may be conveyed by thought or sound or by a glance, or increased by strong breathing."

Those who accept no evidence save that of their five physical senses will look upon this remarkable book as foolishness, but enlightened physicians and courageous seekers after truth will welcome and profit by it.

MEDICAL NEWS

(c) Keystone View Co.

Chinatown's Youngest Woman Physician

ONLY 25 years old, Dr. Helen Tong-Chinn (shown here) is the youngest woman physician in San Francisco's Chinatown. She is a graduate of the University of California Medical School and now serves as a staff member in the famous Chinese Hospital, the only institution of its sort in America. She studied medicine at the request of her father, Sing Fat, a Chinatown merchant.

College of Physicians Meeting

THE publication of this notice may seem like a work of supererogation, because the fellows and associates of the American College of Physicians generally look forward to its meetings with keen eagerness, but, lest any such may have overlooked the matter, this is a reminder that the 1935 meeting will be held in Philadelphia, Pa., April 29 to May 3. The editor of this Journal hopes to be there and to present to our readers who are so unfortunate as to be unable to attend, soon thereafter, a report of the meeting.

Civil Service Examination

THE United States Civil Service Commission has announced open competitive examinations as follows:

Dietitians

Applications for the positions of chief dietitian, head dietitian, and staff dietitian in the Public Health Service and the Veterans' Administration must be on file with the U. S. Civil Service Commission at Washington, D. C., not later than March 25, 1935.

Appropriate education and experience are required.

Full information may be obtained from the Secretary of the United States Civil Service Board of Examiners at the post office in any city which has a post office of the first or the second class, or from the United States Civil Service Commission, Washington, D. C.

European Clinical Assemblies

THE eleventh tour of the European clinics, sponsored by the Interstate Postgraduate Medical Association, will start from New York on May 17, 1935, take in England, Scotland, Norway, Sweden, Denmark, Finland, Russia, Poland, Germany, Austria and France, and will arrive back in New York on July 11. It will be a wonderful opportunity.

For complete information, write to Dr. W. B. Peck, Freeport, Ill.

Dr. Pilcher Passes

THE dean of the medical editors of the United States, Dr. Lewis Stephen Pilcher, editor of *Annals of Surgery* for half a century, passed to rest from his long and valuable labors December 24, 1934, at the ripe age of 89 years. His son, James Taft Pilcher, B.A., M.D., becomes managing editor of the *Annals*, which will go on, as usual, with a strong editorial staff.

A portrait of Dr. Pilcher appeared as a frontispiece in our March, 1934, issue, with a brief biography on page 110. It would be well to read again this record of a busy and fruitful life.

Food Values

AN excellent brochure containing charts of food values ("Nutritional Charts") can be obtained, without cost, by any physician, dentist or dietitian who will write for it to the H. J. Heinz Co., Pittsburgh, Pa.

SEND FOR THIS LITERATURE

TO ASSIST doctors in obtaining current literature published by manufacturers of equipment, pharmaceuticals, physicians' supplies, foods, etc., CLINICAL MEDICINE AND SURGERY, Waukegan, Ill., will gladly forward requests for such catalogs, booklets, reprints, etc., as are listed from month to month in this department. Some of the material now available in printed form is shown below, each piece being given a key number. For convenience in ordering, our readers may use these numbers and simply send requests to this magazine. Our aim is to recommend only current literature which meets the standards of this journal as to reliability and adaptability for physician's use.

Both the literature listed below and the service are free. In addition to this, we will gladly furnish such other information as you may desire regarding additional equipment, or medicinal supplies. **Make use of this department. Ask for clinical samples where these are offered.**

E-47 Campho-Phenique in Major and Minor Surgery. Campho-Phenique Company.

E-596 The Pneumonic Lung. Its Physical Signs and Pathology. The Denver Chemical Mfg. Co.

E-610 Bischoff Pharmaceutical Specialties. Ernst Bischoff Co., Inc.

E-611 Vera-Perles of Sandalwood Compound. The Paul Plessner Company.

E-612 Taurocol. The Paul Plessner Co.

E-613 Specific Urethritis — Gonosan "Riedel." Riedel & Co., Inc.

E-636 Science's latest contribution to female sex hormone therapy — Progynon. Schering Corporation.

E-642 Ergoapiol (Smith) and Glykeron—(for sample, send narcotic registry number). Martin H. Smith Co.

E-669 The Illinois Post Graduate Medical School Bulletin. The Illinois Post Graduate Medical School, Inc.

E-672 Inflammation and Congestion. Numotizine, Inc.

E-720 National Hay Fever Antigens. The National Drug Company.

E-725 *The Hormone*—July, 1934. The Harrower Laboratory, Inc.

E-737 Descriptive Booklet. Od Peacock Sultan Co.

E-742 Dilaudid a Morphine Derivative. An Advance in Opiate Medication. Bilhuber-Knoll Corp.

E-746 Dr. Weirick's Sanitarium. Dr. G. A. Weirick.

E-752 Fourth Edition of Diagnosis of Genito-Urinary Diseases and Syphilis. Od Peacock Sultan Co.

E-759 From "Poultesse" to "Cataplasm-Plus." Numotizine, Incorporated.

E-761 For the Failing Heart of Middle Life —Theocalcin. Bilhuber-Knoll Corp.

E-771 Anabolin—The standardized liver principle. The Harrower Laboratory, Inc.

E-774 Adreno-Spermin. The Harrower Laboratory, Inc.

E-780 The Intravenous Injection of Hydrochloric Acid. Loeser Laboratory.

E-781 Dysmenorrhea — Hormotone. G. W. Carnrick Co.

E-785 Endo Liver Extract in the Treatment of Pernicious Anemia. Endo Products, Inc.

E-792 The Last Three Months. William R. Warner & Company, Inc.

E-794 *Journal of Intravenous Therapy*. Loeser Laboratory.

E-799 Whooping Cough Successfully Treated with Elixir Bromaurate (Elixir Gold Tribomide). Gold Phamacal Co.

E-800 Introducing to Physicians Only; a dependable form of Vaginal Hygiene—Ortho-Gynol. Johnson & Johnson.

E-808 Facts About Ortho-Gynol for Physicians. Johnson & Johnson.

E-809 Disorders of the Female Sex Cycle. Schering Corporation.

E-811 Edwenil; A Polyvalent Antibacterial Agent for use in Endotoxic Infections. Spicer & Co., Inc.

E-813 Literature on Pyridium For The Treatment of Genito-Urinary Infections. Merck & Co., Inc.

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E-817 The Rationale of the Synergistic Tonic. The Purdue Frederick Company.

E-818 Menocrin. The Harrower Laboratory, Inc.

E-819 Psorimangan Injections; The Efficacious New Method for the Treatment of Psoriasis. The Koenig-Psorimangan Company.

E-822 Metaphen in Agar. Abbott Laboratories.

E-824 Chondroitin; for the treatment of Idio-Pathic Headache. The Wilson Laboratories.

E-825 Hyperol; A Utero-Ovarian Tonic and Corrective. The Purdue Frederick Company.

E-826 Eyes in the Night. Schering & Glatz, Inc.

E-828 Infected Wound Therapy. The Denver Chemical Mfg. Co.

E-830 Obesity from an Underactive Thyroid—Thyractin. The Winthrop Chemical Co.

E-831 Quinine Formulary. Merck & Co.

E-832 Endothyrin for Use in Hyperthyroidism, etc. Harrower Laboratory.

E-833 Novaldin. Winthrop Chemical Co., Inc.

E-834 The Endotoxic Infections and their Control with Edwenil. Spicer & Co.

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E-846 Prophenal; Hypnotic, Sedative, and Anti-spasmodic. Zemmer Co.

E-848 Diagnosis of Genito-Urinary Diseases and Urinalysis. (Berger). Od Peacock Sultan Co., St. Louis, Mo.

E-849 Hemorrhoids—Differential Symptoms and Suggestions for Treatment. Schering & Glatz.

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